UPPSALA STUDIES
IN EDUCATION 6

Henry Werlinder

Psychopathy: A History of the Concepts

Analysis of the origin and development of a family of concepts in psychopathology

1978

ACTA UNIVERSITATIS UPSALIENSIS

ACTA UNIVERSITATIS UPSALIENSIS
Uppsala Studies in Education
6

Distributor: Almqvist & Wiksell International, S-101 20 Stockholm, Sweden

Psychopathy: A History of the Concepts

Analysis of the Origin and Development of a Family of Concepts in Psychopathology

by
Henry Werlinder
Skånel. nation

DOCTORAL DISSERTATION
to be publicly examined in Hörsal 1, HSC, Uppsala university,
on May 29, 1978, at 10 a.m.,
for the Degree of Doctor of Philosophy

Abstract This dissertation deals with the *historical development* of current *psychopathy concepts*. Purposes: (1) to contribute to the history of psychopathology in general; (2) to elucidate the obscurities still prevailing in the field. Often overlooked in the debate, a large number of partly different concepts have been used (e.g. *moral insanity, moral imbecility, constitutional inferiority, psychopathic personality, sociopathy*). Three main lines of thought can be discerned. Beginning around 1800 in France affective disorders in mental illness are stressed (Pinel). The second line from around 1860 is connected with the idea of *degeneration* (Morel). Mental anomalies is now seen as primarily *hereditary* (*polymorphic heredity, progressive deterioration*). The notion of a series of disorders within the borderland between mental health and mental illness, having a fragile nervous system i common, is the basis of the psychopathy concept of the German Koch (1888). This concerns a series of clinically disparate but relatively stable *abnormal personalities* which have been seen as hereditary. A third current, the "Anglo-Saxon", may be traced back to the American Rush (1786), and will thereafter reappear in literature (Anglo-Saxon as well as Continental) until nowadays. It is here a question of a rather limited "syndrome", the core of which is, according to many writers, an *inadequate control of impulses* and an *inability to empathize* (secondary traits: *remorselessness, egoism, aggressiveness, now-orienting actions, asociality*, etc.). During the 20th century this descriptive psychopathy "syndrome" has primarily been isolated within the Anglo-Saxon psychopathology and it is now internationally advancing, thereby superseding its German counterpart. That is the case in e.g. Sweden. Emphasis has in the thesis been laid on the fact that Prichard's "moral insanity" (1835) is not the origin of this concept, which has been alleged. This "syndrome" has initiated a diversified research activity. However, now as earlier, environmental and organically oriented theories oppose each other. The psychopathy concept has had, and still has, a derogatory connotation which probably is unavoidable. Despite this it may have some practical use, if it could be more unambiguously defined and if a dimensional approach were substituted for the traditional categorical one.

ISBN 91-554-0782-X
ISSN 0347-1314

218 pp.

Uppsala 1978

Digitized by the Internet Archive
in 2026

https://archive.org/details/IA41548924_0022

ACTA UNIVERSITATIS UPSALIENSIS
Uppsala Studies in Education
6

Psychopathy: A History of the Concepts

Analysis of the origin and development of a family of concepts in psychopathology

Henry Werlinder

Uppsala 1978

Distributor:
Almqvist & Wiksell International
Stockholm

Doktorsavhandling vid Uppsala universitet 1978

ISBN 91–554–0782–X
ISSN 0347–1314

Abstract This dissertation deals with the *historical development* of current *psychopathy concepts*. Purposes: (1) to contribute to the history of psychopathology in general; (2) to elucidate the obscurities still prevailing in the field. Often overlooked in the debate, a large number of partly different concepts have been used (e.g. *moral insanity, moral imbecility, constitutional inferiority, psychopathic personality, sociopathy*). Three main lines of thought can be discerned. Beginning around 1800 in France affective disorders in mental illness are stressed (Pinel). The second line from around 1860 is connected with the idea of *degeneration* (Morel). Mental anomalies is now seen as primarily *hereditary* (*polymorphic heredity, progressive deterioration*). The notion of a series of disorders within the borderland between mental health and mental illness, having a fragile nervous system i common, is the basis of the psychopathy concept of the German Koch (1888). This concerns a series of clinically disparate but relatively stable *abnormal personalities* which have been seen as hereditary. A third current, the "Anglo-Saxon", may be traced back to the American Rush (1786), and will thereafter reappear in literature (Anglo-Saxon as well as Continental) until nowadays. It is here a question of a rather limited "syndrome", the core of which is, according to many writers, an *inadequate control of impulses* and an *inability to empathize* (secondary traits: *remorselessness, egoism, aggressiveness, now-orienting actions, asociality,* etc.). During the 20th century this descriptive psychopathy "syndrome" has primarily been isolated within the Anglo-Saxon psychopathology and it is now internationally advancing, thereby superseding its German counterpart. That is the case in e.g. Sweden. Emphasis has in the thesis been laid on the fact that Prichard's "moral insanity" (1835) is not the origin of this concept, which has been alleged. This "syndrome" has initiated a diversified research activity. However, now as earlier, environmental and organically oriented theories oppose each other. The psychopathy concept has had, and still has, a derogatory connotation which probably is unavoidable. Despite this it may have some practical use, if it could be more unambiguously defined and if a dimensional approach were substituted for the traditional categorical one.

© Henry Werlinder, 1978

Printed in Sweden by
Borgströms tryckeri, Motala 1978
Photo typesetting by
TEXTgruppen, Uppsala

Contents

Preface 7
1 Introduction 9
2 Historical Roots of the Psychopathy Concepts 15
2.1 Currents in Philosophy and Medicine of the 18th Century 15
2.2 Partial and Affective Insanity 18
2.3 The Meaning of the Term Moral 21
2.4 Two Prominent Figures 24
2.4.1 Rush: Disease in the Moral Faculty 24
2.4.2 Pinel: Mania without Delirium 26
2.4.3 The Contributions of Rush and Pinel: A Comparison 30
2.5 Theory of Monomania 32
2.6 The Early Moral Insanity Concept 36
2.6.1 Prichard: Moral Insanity 36
2.6.2 Debate in America on Moral Insanity 41
2.6.3 The Moral Insanity Concept in France and Germany up to the 1860s 48
2.7 Summary 49
3 Heredity and Degeneration within Psychopathology 52
3.1 The New Medicine and Its Influence on Psychopathology 52
3.2 Development of the Theory of Degeneration 55
3.2.1 Background 55
3.2.2 Morel and His Theory 56
3.2.3 Continuing Developments in France 60
3.2.4 The Theory of Degeneration in German Psychiatry 65
3.2.5 Reasons for the Decline of the Theory of Degeneration 66
3.3 Summary 67
4 "Moral Insanity" as a Form of Degeneration 69
4.1 French Views 69
4.2 Lombroso: The Born Criminal 71
4.3 The German Concept of Moral Insanity 75
4.4 Developments in Great Britain after 1860 80
4.5 Summary 84
5 Developments of the German Notions of Psychopaty 86
5.1 Initial Phase 86
5.1.1 Koch: Psychopathic Inferiorities 86
5.1.2 Ziehen: Psychopathic Constitution 90
5.1.3 Kraepelin: Psychopathic Personality 93
5.1.4 Some Other Contributions 97

5.2 The German Concepts of Psychopathy from the 1920s to the Present 100
5.2.1 Kretschmer's View of Psychopathy 100
5.2.2 Kurt Schneider's Theory of Psychopathy 104
5.2.3 The Nature-Nurture Problem and Its Relationship to the Concepts of Psychopathy and Neurosis 112
5.2.4 Concept of Psychopathy in France 117
5.2.5 The Concept of Psychopathy in Scandinavia 119
5.2.6 Reasons for the Decline of the German Approach to Psychopathy 126

5.3 Summary 127

6 Growth of the Modern Anglo-Saxon Psychopathy Concept 131
6.1 Developments in Great Britain 121
6.1.1 Debate on the Concept Moral Imbecility 131
6.1.2 Henderson's Psychopathy Concept 135
6.1.3 Continuing Developments in Great Britain 139

6.2 Developments in America 142
6.2.1 The Contribution of Adolf Meyer 142
6.2.2 Other Early Opinions on Psychopathy 145
6.2.3 The Psychopathy Symposium of 1923 147
6.2.4 Partridge: Sociopathy 149
6.2.5 Psychopathy Diagnosis around 1940 152
6.2.6 Views of Psychoanalysis on Psychopathy 154
6.2.7 Karpman's Psychopathy Concept 161
6.2.8 Cleckley's Psychopathy Concept 164
6.2.9 Continuing Developments in America 167

6.3 Modern Anglo-Saxon Theories on Psychopathy 170
6.4 Summary 173

7 Summary And Discussion 178
7.1 Introduction 178
7.2 Some General Tendencies and Lines of Development 178
7.3 Viewpoints on Psychodiagnostic Concepts 182
7.4 Observations and Conclusions 186

Appendix 191
References 193

Preface

At a time when clinical psychological and psychiatric work is characterized by a spirit of renewal and forward vision, an historical investigation in the area may perhaps seem unjustified. Through my work I wish to demonstrate that such is not the case. This applies especially when considering investigations of clinical phenomena, our knowledge of which is still inadequate and before which we consequently stand in bewilderment. Of course research oriented to the present is indispensable in such areas. However, the contributions of historical analysis are the observations and attempts at systematization made by clinicians and researchers of other times. These are experiences that are unique, because the conditions under which they were made will never recur. They should be preserved and utilized.

I want to express my deep gratitude to Professor W. Sjöstrand, former Head of the Institute of Education, University of Uppsala. His continuous interest, stimulating criticism and accuracy have been of great value for me. I also wish to thank my fellow-workers at Statens Rättspsykiatriska Klinik, Uppsala, and Docent K.E. Törnqvist, Head of the clinic, for their help and encouragement. Dr M.L. Troy is gratefully acknowledged for his translation of my dissertation into English. However, the most cordial thanks I want to address to my wife Lena and our children Carl, Pontus and Lisa. Apart from their active help they have had to sacrifice a great deal in order to give me the time, peace and quiet that serious research always demand.

Uppsala, March 1978

Henry Werlinder

1 Introduction

> Where history is lacking mythology takes its place and those who disdain history are among the foremost victims of mythology.
>
> Owsey Temkin (1945, p. 10)

The history of psychopathology is dominated to a great extent by debate on diagnostic concepts. Certainly the situation has improved since the 1800s, when seemingly every soul doctor with any self-respect created his own nosological system, but the classifications are still many and the number of diffuse concepts even greater.[1]

Among the latter, the psychopathy concept is in a class by itself. From the time it began to take shape nearly 200 years ago (see chap. 2, below) until the present day, the concept has been the object of disagreement and debate of seldom-witnessed intensity.[2] The study of the history of the psychopathy concept—or rather the group of concepts[3]—gives insight into a veritable "chamber of horrors of obsolete theories and a swamp of conceptual confusion" (Törnqvist 1956, p. 1).*

* Citations which have been translated by the author will be followed throughout by an asterisk.

[1] "To give a comprehensive nosology, to classify carefully, to produce a well-ordered classification almost seems to have become the unspoken ambition of every psychiatrist of industry and promise, as it is the ambition of a good tenor to strike a high C. This classificatory ambition was so conspicuous that the composer Berlioz was prompted to remark that after their studies have been completed a rhetorician writes a tragedy and a psychiatrist a classification" (Zilboorg & Henry 1941, p. 450).

[2] Karpman (cf. section 6.2.7), an American researcher who has for many years worked with the psychopathy concept writes for example (1950, p. 233): "There is no nosological condition in the entire field of psychiatry on which there is so little agreement, and which is subject to so much misunderstanding and equivocation as that of psychopathy and psychopathic personality". My own research confirms this. On the other hand see those results arrived at by Gray & Hutchison (1964) and Albert et al. (1959), below in this section. They refer, however, to the more homogeneous Anglo-Saxon concept of psychopathy (see chap. 6).

[3] I will at times refer to the *psychopathy concept*, despite the fact that this is actually a question of a number of different delimitations. However, these are related if in a very complicated fashion. Consequently I feel I am justified in using "concept" in the singular in certain contexts, though cognizant that a whole family of concepts is intended. At other times I have employed the plural form as for example in the title of the dissertation (Psychopathy: A History of the Concepts). This is the case when I wish to emphasize that psychopathology has concerned itself with quite different

What then is meant by "psychopathy?" That was my initial inquiry, and I found that there seemed to be no clear-cut answer. The lack of definitional clarity in this basic question was the motivating force for a study that eventually developed into a survey of the entire history of this protean concept. The results of my work are related in the present dissertation.

The psychopathy concept has been the object of severe criticism in recent years, both from theoreticians and those engaged in the actual warding of human beings. Some have stated that the concept is too encompassing, its contoures too vague. Its diffuse nature has meant that it has become a rubbish heap for generally difficult to diagnose conditions on the outskirts of the domain of psychopathology (see Bowlus & Shotwell 1947/48, p. 23). The term brings together, according to Gerle (1947, 1955), a number of behavioral abnormalities that have very little in common, and it should thus be declared bankrupt.[4] Kinberg (1946), who shares this opinion, considers accordingly that the term psychopathy comes nowhere near filling those requirements one has a right to demand of a clinical diagnosis. He continues (p. 176):

> It gives an incomplete, warped and misleading knowledge. It bolsters up thought laziness and is an obstacle to the progress of clinical and scientific thought in psychopathology. Therefore it should be abrogated as theoretically unsatisfactory, practically misleading and destructive to scientific thinking in psychopathology.

Another type of criticism is directed at the rubber-stamping that is considered to be associated with psychiatric diagnoses such as psychopathy. Representatives for this view claim that such labels often do more harm than good, since those who read and hear them gain an unnuanced and thus false picture of whom it concerns (see e.g. Ullman & Krasner 1969, esp. chap. 2). Those that have been labelled psychopaths are often confronted by a variety of negative expectations that can easily become self-fulfilling prophesies.[5]

All this criticism has not, however, led to the abandonment of the psychopathy concept. According to Rylander (1968, p. 126) it can, despite its inadequacies,

conceptions of psychopathy. This has not been sufficiently noted which has in turn led to many long meaningless debates.

I have further chosen to use the *word* psychopathy in the dissertation despite its negative emotional charge. It is the most established of all those synonyms that have been employed to indicate "psychopathy" (see appendix). No such appellation can for that matter avoid acquiring a depreciatory tone after a period of use, since the fact is that they symbolize behavior which most in our society strongly oppose.

[4] This critique is primarily aimed at the German conceptions of psychopathy, which were among those dominating in Swedish psychiatry until the 1950s. Thereafter the more limited Anglo-Saxon view has replaced the German to an increasing extent. The latter is, however, still current on the European continent, which is a state of affairs giving rise to misunderstanding and unclear thought. See further chaps. 5 and 6.

[5] Merton (1949) speaks of "self-fulfilling prophecy". Those expectations which for example hospital personnel have regarding patients control their own behavior vis-à-vis those being warded, which influences in turn the latter's self-image. Consequently they begin to act according to the expectations of the personnel.

"for the present not be spared in psychiatry". There are in fact investigations which indicate that the concept is generally apprehended as meaningful.

In 1964 two researchers, Gray and Hutchison, sent out a questionnaire to 937 Canadian psychiatrists, intending to survey their views on psychopathy. Of the 677 persons answering the questionnaire approx. 90 per cent considered the diagnosis useful. In 1959 another research group, Albert, Brigante and Chase, performed a content analysis of 70 scientific articles on psychopathy. They found that, despite all that has been written about the diffuse nature of the concept, there is considerable agreement among researchers in the area as to what is intended by this diagnosis.[6] Also, in recent years a type of research has developed which attempts to define the concept by relating psychopathic behavior to test results, physiological responses, etc. (see e.g. Hare 1970).

Thus it must be stated that the psychopathy concept is still current, but that opinions of it differ widely. To contribute, through an historical analysis, to a clarification of these many conceptual nuances has seemed to me to be an important task. Building a foundation of background knowledge gives scope for judgements of current questions of psychopathy and will surely give us clearer vision in the planning of future research and treatment in this area.[7]

An historical study has, however, a considerable value independent of immediate practical usefulness. The history of the psychopathy concepts has not, in

[6] The Anglo-Saxon idea of psychopathy is meant here. See chap. 6.

[7] Cf. e.g. Shafer 1969, p. 9; Temkin 1946, p. 46; Renwall 1965, p. 272. To put forth utilitarian points of view is certainly a temptation especially for that researcher whose work is intended in part for an audience less knowledgeable in history. For the historian himself his results have an undeniable value which, in case similar to that of music or art cannot and need not always be motivated in terms of immediate usefulness (cf. e.g. Torstendahl 1966, pp. 40 ff.).

Early historians of medicine were happy to emphasize the pragmatic side of their activities. In times past a knowledge of history was a necessity for physicians, since their activities were based to a great extent on historic authorities (see e.g. Heinroth 1818). However, with the progress in medicine in the last 150 years medical history has lost its immediate practical significance. As is well known, medical science has been divided into an increasing number of specialities. In this new situation, certain medical historians had hoped that their knowledge might serve as a link between the different medical disciplines (see Temkin 1946). However, this is not the direction which developments have taken. The physician of today most often knows very little about the development of his science. Medical historians naturally see this state of things as unfortunate.

Certainly, they do not consider that the individual physician becomes more skillful if he is acquainted with medical history. Historical knowledge has, however, a definite role in research. "The utility of medical history, as of history in general", writes Galdston (1975, p. 5), "derives from the fact that history is that discipline which exposes and expounds the basis upon which judgement can best be founded". This statement certainly has more than one sense, but obviously the writer also means that the past reflects human experiences which ought not to be neglected. Historical symptom descriptions and nosological systems, too, are founded on human observations and analysis.

In the foreword to his *Psykiatriens Historie* Beyerholm (1937) gives another reason for historical research within, as he expresses it, the "highly incomplete discipline" psychiatry. He writes (p. 5): "He who wishes to seek new paths should first take care to become well acquainted with the fateful mistakes made in the past, so that these may serve as signposts at the many blind alleys and unproductive detours that predecessors have in all good faith been tempted to try".*

its entirety, been written previously,[8] so that a work concerned with the area fills a gap in our knowledge of the development of psychopathology.

The present dissertation attempts to give as objective as possible an account of the origin and development of the concepts here gathered under the term psychopathy. In so doing I have of course attempted to follow accepted principles for historic research.[9] My presentation begins with the final years of the 1700s and the growth of those ideas which would develop into the psychopathy concepts of our times. Thus the dissertation covers a period of nearly two centuries. It is of course impossible to completely relate all the research and controversy concerned with the various notions of psychopathy and their predecessors during this period. Nor is it, in my judgement, necessary to do so. I have attempted to outline the growth of the concepts of psychopathy in overview, tracing various lines of thought and relating these to more general ideas and events of the time. My material has proven more than sufficient to accomplish this aim.

The problem has been rather one of selection. For the period up to the 1860s, the data points unanimously towards some few central figures, for example Pinel and Prichard, so that the problem of selection has not been difficult. The latter part of the 1800s has been more problematic. Even dealing with this period, however, it eventually became clear that there existed a sufficiently small group of

[8] Few comprehensively intended historical investigations of the psychopathy concept have been published. Most are of a summary character, such as introductions of researchers to presentations of their own theories in the area. Unfortunately, they often contain misinformation. Cf. e.g. Partridge 1930/31; Preu 1944; Gerle 1947, 1955; McCord & McCord 1956, 1964; Craft 1966. There are also historical sketches in certain reports and textbooks, e.g. SOU 1942:59; SOU 1952:46; Henderson 1939, 1944.

As far as I have been able to determine the most detailed contribution to date has been that of Maughs (1941). However, his description which is now almost 40 years old has significant methodological weaknesses. The author relys entirely on English language publications. Regarding German and French psychiatry of the 1800s, so important in this context, he depends completely on translations and citations from English-language journals. This is unsatisfactory, leading to a number of obvious errors. An example is his statement that it was a German named Ettmüller who, at the end of the 18th century made "the initial observations on the condition now known as psychopathic personality", and he called the condition *melancholie sans délire* (Maughs 1941, p. 330). Ettmüller actually lived between 1644 and 1683, and the nature of the condition he termed *melancholia sine delirio* is unclear. See Ettmüller, "De morbis humani in genere", pt. II, chap. 14, in *Opera omnia*, Frankfurt am Main 1688, p. 492. The data are taken from Carlson & Dain 1962, p. 131.

Even more disquieting is Maughs' lack of an historic empathy. He makes little or no attempt to penetrate that intellectual realm which lies behind the many terms and concepts from times past. His version of the history of the psychopathy concepts becomes an enumeration of those authors who have had opinions on the "syndrome" which contemporary Americans term "psychopathic personality".

[9] Attention should perhaps be drawn to the fact that in my historical analysis I have chosen to operate primarily within the approach of the behavior sciences. This view distinguishes most psychopathological theories. Of course, "psychopathy" and other psychodiagnostic concepts can also be studied from a sociological perspective. In this respect it would seem important to investigate e.g. the relationship between these concepts and prevailing socio-economic and political conditions.

influential authors that the majority of them might be referred to.[10] Our own century has given me the greatest selection problems, dependent partly upon the great amount of literature,[11] partly too because of the foreshortened historical perspective. Reviewing the relevant literature I have, however, attempted to build an idea of which researchers and authors have most influenced developments, or have distinguished themselves in some other way. It is upon these that I have concentrated. In this process of selection I have of course taken note of what other authors have observed in the questions touched on.

I have chosen relatively often to group the material around significant individuals. This is, I believe, an historically accurate approach to the earlier period the dissertation deals with—the central innovators and researchers influenced development to a great extent—but in this manner I hope as well to most easily present my results to the reader.

A considerable amount of biographical data appears in the notes, since I assume that such information is of interest to the reader. It contributes also to an understanding of the period of the individual being discussed. The closer to our own times we move, the more I have reduced the amount of such information.

As I have reviewed the psychopathy literature it has become increasingly clear that many problems and misunderstandings have arisen as a result of the fact that attention has not been paid to certain fundamental distinctions. At times the *terms* have been confused with the *concepts*, with little awareness that different terms do not always reflect differing concepts. On the other hand it is not uncommon to find that the same word is employed to signify several notions. Finally, we occasionally find that the concept is being confused with those *phenomena*, i.e., those parts of "reality" with which somebody is concerned.

I have had little opportunity for depth study in those questions of epistemology and philosophy of science related to what has just been said, most especially because it seems to be difficult to achieve generally acceptable standpoints. However, it does seem reasonable to view these matters as follows.

The task of science is to determine what is true. By truth is meant, according to some authorities, those qualifiers that are consonant with "reality" (see e.g. Marc-Wogau 1963, pp. 250 f.). It is then important to distinguish between those phenomena being investigated (e.g. a certain behavior), those characteristics that are found and ordered in concepts (e.g. "psychopathy" as certain described qualifiers), and those names or terms employed for the concepts (e.g.

[10] However, the Italian criminologists and psychiatrists, influential around the turn of the century, have been passed over. Apart from Lombroso (see section 4.2), it has not been possible to refer to them, partly for linguistic reasons, partly because the works that do exist in translation are difficult to obtain.

[11] See e.g. what Kallwass (1969, p. 1) writes about contemporary literature on psychopathy: "Solely the German-language literature on this problem is nowadays so comprehensive as not to be surveyed".*

"psychopathy", "psychopathic personality", "behavior disorder"). Least important in itself is what labels are given to the concepts arrived at, even if it is of course practical to have distinctive designations. More important both from theoretical and practical points of view is that the concepts are clearly defined, so that their content and scope are unambiguously evident. In this way those who come in contact with the concepts (psychologists, educators, social workers, psychiatrists, lawyers, etc.) will be given a fairly definite idea of that segment of "reality" that is intended when certain terms are used (e.g. "psychopathy").[12]

[12] Regarding these questions see further section 7.4.

2 Historical Roots of the Psychopathy Concepts

2.1 Currents in Philosophy and Medicine of the 18th Century

The period around the year 1800 comprises a decisive phase in the history of psychiatry.[1] During the last part of the 1700s psychiatry begins to distinguish itself as a particular medical discipline, and during this period one encounters a significant quantitative upswing in the publication of psychiatric literature (Ackerknecht 1957, p. 32). However, during the last decade of the 18th century and the first years of the19th, a number of practical and theoretical contributions are made which are also qualitatively distinguished from the soul healing of earlier eras. Additionally physicians appear at this time who see the care of "lunatics" as their primary task. Thus it is possible to speak of psychiatrists in the meaning the word has today.[2]

[1] When present-day historians place the birth of modern psychiatry in the period immediately after the French Revolution they are in the main thinking of the humanitarian and treatment-oriented attitude to the mentally disturbed which was then growing. At this time the systematic, empirical study of the mentally ill had also begun. It was to be of great significance for coming developments, though the actual research results were meagre.

When exactly one wishes to date the origin of *scientific* psychiatry depends naturally on the meaning of "scientific" and "psychiatry". Those preferring a theory strictly within natural science will certainly hesitate to call Pinel's attempts at classification and treatment "scientific". Others will tend rather to place emphasis on his empirical approach. A further group claims that scientific psychiatry must not be identified with the extremely limited type of research which, in accordance with the science of internal medicine at the middle of the 19th century, sought to relate mental symptoms to post-mortem discoveries in the brains of deceased patients. Cf. Ackerknecht 1957, p. 32; Alexander & Selesnick 1966, p. 112; Baruk 1967, p. 4; Beyerholm 1937, p. 165; Mora 1961, p. 26; Schneck 1960, p. 99; Sigerist 1944, p. 30; Zilboorg & Henry 1941, p. 318.

It can be of interest to see what one of the prominent intellectual heirs of Pinel has to say in this question (Falret Sr. 1864, p. i): "That current of ideas which developed within mental medicine towards the end of the last century was of a double nature: it was at the same time philantrophic and scientific, and in an evaluation of the progress made within our specialization during that period it is impossible to separate these two aspects of scientific development".

[2] So far as is known the term psychiatry was coined during the first years of the 19th century, but came into general use only later. In Germany the term was used relatively often as early as the middle of the century, in France it won ground only more gradually and in the English-speaking world it does not seem to have achieved dominance over competing terms until the 20th century.

The originator was in all likelihood the German physician Johann Christian Reil (1759–1813). The word *Psychiaterie* is found a number of times in his *Beyträge zur Beförderung einer Kurmethode auf psychischen Wege* (Contributions to Further a Method of Treatment by Mental Means), published in 1808. Reil reasons that neither psychic nor surgical medicine can actually exist. Medicine is a technical science which refers to pure natural knowledge, while so-called psychic medicine is related to philosophy or, as we prefer to phrase it today, psychology. Man has three "receptivities", the psychic, the physio-chemical and the mechanical. Accordingly, one should speak of *Psychiaterie*, medicine and surgery. Consequently, for Reil *Psychiaterie* is that medical art

During the 1700s medicine had hardly distinguished itself for its scientific accomplishments. Above all this was the century of grandiose rationalist systems. Even so, alongside this speculative medicine a tradition of empirical research began to develop.[3] Consequently one encounters such extremely different research personalities as John Hunter (1728–93) and John Brown (1735–88), active during the same period, both residing in London. The former was an anatomist with a burning interest for knowledge of exact details, the latter a builder of speculative systems for whom the question of empirical verification never had any real actuality.[4] Other 18th century empiricists eminent for the explosive developments in medicine in the coming century included Giovanni Battista Morgagni (1682–1771) and Albrecht von Haller (1708–77).[5]

The limited successes within anatomy and physiology during the 1700s had little practical significance for the growing field of psychiatry. It was above all the ideas of the Enlightenment which were to be the decisive impulses.[6]

which employs psychological methods or, as Reil expresses it, *psychische Curmetoden* (see Reil 1808, vol. 1, pp. 168 f.).

This triple division is also found in the author's earlier *Rhapsodieen* (Reil 1803, pp. 24 ff.). There, however, one reads only of *psychische Heilkunde*, so it can be assumed that the term *Psychiaterie*, which is etymologically synonymous (cf. Gr. *iatrei'a*, art of healing), has been created in the interim period, that is, between 1803 and 1808.

In the more modern form *Psychiatrie* the word appears a few times in the work of Heinroth (1818, vol. 1, p. 63), but to judge by frequency of use, this author prefers the more established *psychische Medizin*. Otherwise he uses expressions like *psychischer Arzt, das psychisch-ärztliche Geschäft, eine psychisch-ärztliche Theorie*, etc., not *psychiatrisch*. Cf. *Am. J. Psychiat., 107*, 1950/51, pp. 628, 868 f.; Grange 1961, p. 442 f.; Hunter & Macalpine 1963, p. 952; Veith 1965, pp. 184 f.

[3] Cf. e.g. Rosen 1951, p. 153; King 1971, p. 161. It is worth observing that "even the confusion of medical 'systems' was a sign of progress *ipso facto* evidence that new facts and ideas were accumulating rapidly" (Shryock 1936, pp. 58 f.).

[4] Cf. e.g. King 1971, pp. 26 f., 160 f.

[5] Morgani was one of the first pathologists to perform dissection on the brains of deceased mental patients. Beyerholm (1937) comments negatively on this and on the reported finds of other contemporary pathologists: "A considerable portion of the finds can be considered to be artificial products, decomposition phenomena or inaccurate evaluations based on inadequate knowledge of the normal brain - - - " (p. 155).* However, through his careful and comprehensive pathological examinations of the human body Morgani could disprove the classical pathology of humors. He demonstrated how the processes of disease were linked to different organs, thus initiating the medical trend towards localization which culminated with Virchow (1821–1902) and his cellular pathology (cf. e.g. Shryock 1936, p. 150). Nor did this trend bypass psychiatry (cf. section 3.1, below).

Haller's findings in respect to the functioning of nerves and muscles (sensitivity and irritability) soon had an affect on the medical theories of the day. The influential Scottish physician William Cullen (1710–1790) considered the sensitivity of the nervous system to be the ground of his pathology. It is from Cullen that we have the term neurosis, which for him covered a wide number of diseases, among others the *Vesaniae* which on the whole encompassed the psychoses of today.

[6] The general optimism which characterizes many of the philosophers and scientists of the Enlightenment is probably based to a large extent on the progress made in the natural sciences during the 17th and 18th centuries. When it is a question of the view of mental illness and its cure held around the year 1800, the enthusiasm and optimism is a result of the same general faith in the possibilities of man. In this sense the anatomical, physiological and pathological research of the 1700s also had an influence on psychiatry.

With its belief in common sense and its disgust with all things that might be associated with superstition, the philosophy of the Enlightenment gave the death blow to the old idea of demonic possession, which was still entertained by many—including doctors.[7] There is perhaps also reason to mention the witchcraft trials in this context, for they had not ceased in the West until the century of the Enlightenment.[8]

According to the new perspective, then, "madness" became a natural phenomenon, and for physicians with the revived Hippocratic tradition as background it was natural to interpret the phenomenon medically: "madness" was once again considered a disease, as it had been in ancient times.

It seems natural at this point to question whether this perspective was based on a materialistic philosophy. But it was seldom a matter of materialism in an ontological sense. Some of the representatives of the Enlightenment in France such as Diderot, d'Alambert, La Mettrie and Holbach were certainly atheists and materialists but the most common way of interpreting things was still dualistic. That is to say, soul was considered by most to be an immaterial substance, but its "diseases" were often seen to be the result of disturbances of the material substrata, though hardly always the brain.[9] However, Descartes' strict dualism began to loosen up in favor of sensualistic theories influenced by English empiricism. Locke and Condillac were the leading lights for *les idéologues*, the philosophical group to which Pinel belonged (see e.g. section 2.4.2, below).[10]

Another characteristic of Enlightenment thinking which had importance for the

[7] The German, natural philosophy-oriented physician Heinroth (1773–1843) writes (1818, vol. 1, p. 379): "Say what you will, but without a complete turning away from God there is no mental disturbance. In the presence of God there is strength, light, love and life; with Satan is impotence, darkness, hate and overall destruction. Accordingly, an evil spirit dwells within the mentally deranged; it is he who is truly possessed".* This statement can be interpreted allegorically, but there are other physicians of the nature philosophy school who had full faith in possession, for example Kerner and Eschenmayer. Cf. Kraepelin 1918, p. 34; Ackerknecht 1957, p. 32; Marx 1968a.

[8] As late as 1782 the servant girl Anna Göldi was beheaded in Switzerland for witchcraft. She was probably the last woman in Europe to be executed after due process of law for this sort of "crime" (see Heppe 1880, p. 322). Only seven years earlier a woman accused of being a witch had been beheaded in Bavaria: the last witchcraft trial on German soil to result in the death sentence (ibid. p. 314).

[9] Pinel believed for example that certain psychic ailments arose from disorders of the abdominal organs (cf. Pinel 1806, p. 16).

[10] However, according to Temkin (1946) sensualism was comprehended by spokesmen for the old dualistic viewpoint as materialism: "It was - (the) elimination of an independent spiritual principle that was decried as materialism. It mattered little whether physiologists such as, for instance, Bichat retained a belief in the soul, if only the soul could be neglected in physiological research and as long as psychology was a mere province of physiology" (pp. 322 f.). Cabanis (1757–1808), physician and one of the leaders of *les idéologues*, has also been considered by many to have been a materialist, in spite of his being said to have rejected materialism. A citation has often been taken from his well known *Rapports du physique et du moral de l'homme* (1802), where he claims that the thoughts are the products of the brain as the bile is the product of the liver. For a closer study of *les idéologues* and their philosophy see Rosen (1946).

progress of psychiatry was its humanity. The ideal of equality which found expression in the American Declaration of Independence (1776) and in the French Declaration of the Rights of Man (1789) had consequences also for the unfortunates in lunatic asylums and other such establishments.[11] This new attitude--an attitude which meant that these creatures were once more considered and treated as fellow human beings--was actually the basic precondition for a science of psychiatry.

Also of weight was the fact that in France at this time there were a number of institutions for the care of societal deviates, of which the "madmen" were an important segment.[12] Some of the institutions were quite large, which meant that resident physicians had the possibility to analyze and compare a larger number of cases, which is a necessity for systematic study. Certainly conditions in these institutions were chaotic, but they still comprised a foundation upon which the first empirically-oriented psychiatrists could begin to build their science.[13]

Considering the more important factors behind the growth of modern psychiatry one should not, however, forget that the revolution of 1789 was in itself significant. It meant a violent social upheaval and struck even the medical institutions of *l'ancien régime* and their representatives. New men with more modern ideas thus came rapidly to power and excercised an influence on developments. Pinel is an example of this.[14]

2.2 Partial and Affective Insanity

There are two concepts in the psychiatry of the early 1800s which played an important role in the growth of those views to be the basis of the psychopathy concepts in later times. Often they weave together to such an extent that many later

[11] Contemporary critics have left us many descriptions of the inhuman conditions under which the mentally ill were forced to live long into the 19th century. One example is given by Reil (1803, pp. 14 f.): "As if they were criminals, we lock these unfortunate creatures in madhouses, obsolete prisons, side by side with the holes of owls above the city gates or in the cold damp cellars of penitenturies where the sympathetic glance of another human being never reaches them. There we allow them to rot in their own filth, confined by their chains. Their shackles have eaten into their flesh to the bone and their gaunt and pale faces are sure sign of close death, of a waiting grave to finally muffle their anguished cries and conceal our shame. For a price they are exhibited before the curious mob and the greedy keepers tease them as one does exotic beasts to amuse the idle onlookers".*

[12] Foucault (1961) has given an interesting interpretation of the origin of these institutions in his work *Histoire de la folie à l'age classique* (translated into Swedish, 1973).

[13] In his *Traité* (1800/01) Pinel himself emphasizes the significance of the institutions for the development of an empirical psychiatry: "The principles of free inquiry, which the revolution has incorporated with our national politics, have opened a wide field to the energies of medical philosophy. But, it is chiefly in great hospitals and asylums, that those advantages will be immediately felt, from the opportunities which are there afforded of making a great number of observations, experiments and comparisons" (Pinel 1806, p. 46). Concerning Pinel see section 2.4.2, 2.4.3.

[14] Cf. e.g. Woods & Carlson 1961, p. 14; King 1971, p. 191.

researchers, despite a secure historic distance from the actual concepts and the theories that composed them, have difficulty in keeping them distinct. Both of these concepts have a long past, but it was not until the 1800s that they achieved full development. As the heading to this section indicates, we are referring to "partial insanity" and "affective insanity". We shall here attempt to distinguish and make more precise the content of each term. It has of course been known since time immemorial that there are degrees of lunacy or madness, that some people have been completely mad while others have only in certain respects shown themselves to be eccentric. These observations form the basis of a division of insanity into *total* and *partial* forms, a classification which became increasingly common during the 1700s.

According to certain sources this distinction existed even with the authors of antiquity. In any case it seems to have occurred in the English legal system of the 17th century.[15] The concept of partial insanity was, then, a legal concept connected with the long discussion on imputability. It would remain a legal question of great actuality during the entire 19th century.

It was above all the various forms of "melancholy" that were seen as being partial insanity. With this type of disorder the victim was most often somewhat reasonable, displaying adequate logic in most things, with the exception of certain ideas which it was not possible to influence.

The other concept, affective or moral insanity,[16] is related to the perspective maintained on the importance of the emotions for the anomalies of the mind. As a rule the emotions were not given a dominant position in the psychology of the 1700s. The term "psychology" itself, which seems to have been coined in the 15th or the beginning of the 16th century[17] was, during the century of rationalism, the designation of that philosophy which handled the different faculties and functions of the intellect. Many saw the emotions only as a subordinate accompaniment for the activities of the intellect. For these people it was also natural to describe the origins and symptomatology of mental disturbances in terms of sense, understanding and intellect.

Thomas Arnold (1782)[18] defined the two primary kinds of insanity in the following way:

[15] Prichard (1842, p. 163) writes for example: "Lord Hale, who established the distinction between Total and Partial Insanity made an attempt to point out a sort of criterion". Cf. Herrlin (1904, p. 29). In Magnan & Legrain (1895, p. 6) there are indications that the physicians Zacchias (1584–1659) and Boerhaave (1668–1738) also made such a distinction.

[16] Regarding the term moral see section 2.2.1.

[17] According to Boring (1966), the Yugoslavian, K. Krstić, has found the term *psichiologia* in a bibliography on works by Marco Marolić (1450–1524). The full title of the lost manuscript, which is of unknown date, reads: *Psichiologia de ratione animae humane L(iber) I.* Previously the term had only been known to have been used from the end of the 16th century. For a closer study of the problem see Boring 1966, p. 167; and K. Krstić, in *Acta Instituti Psychologici Universitatis Zagrebiensis, 36,* 1964, pp. 7–13.

[18] Thomas Arnold, *Observations on the Nature, Kind, Causes and Prevention of Insanity, Lunacy, or Madness*, London 1782, vol. 1, p. 30; cited in Carlson & Dain 1962, p. 130. The work has only been available to me in a German translation of 1786.

Melancholy is a permanent delirium, without fury, or fever, in which the mind is dejected, and timorous, and usually imployed about one object. - - - Mania is a permanent delirium, with fury and audacity, but without fear.

Here we find several distinctions, one of them being the different moods characterizing mania and melancholia, well-known to readers of today. A distinctive feature of both kinds of madness is "permanent delirium". The concept of delirium that nowadays signifies "temporary states of confusion, with hallucinations, delusion and motor restlessness" (Renander 1967, p. 108),* was at that time considerably more vague and encompassing. However, it always implied a derangement of reason expressing itself in confusion, incoherent speech, flight of ideas, delusions, hallucinations, etc. Accordingly it was basically an intellectualistic definition that Arnold presented and we also find in it a suggestion that "melancholy" usually signified a *partial* derangement ("imployed about one object"). Considering the development of this perspective on mental disturbances, Carlson & Dain write (1962, p. 130):

From the time of early Greek medicine the definitive characteristic of mental illness—especially the two main categories, mania and melancholia—was 'delirium' - - -. The spectacular scientific advances of the seventeenth century, inspired and exemplified by the work of such men as Galileo, Descartes, Newton and Locke, further reinforced this rationalistic outlook toward mental illness, for these advances strengthened the belief that reason played a crucial role in all man's activities. The eighteenth century perpetuated this attitude and even came to be called the Age of Reason. To this epoch, to lose one's reason was to become insane, and, conversely, to be insane was to have lost one's reason.

But there was also as we know a current of romantic thought through the 1700s and this would eventually break through with full force. Ahlberg writes (1967, p. 427):

If the period of the Enlightenment is the time of reason, so too is it a time of idolation of feeling, a time of sentimentalism such as perhaps no other. - - - All along, the Enlightenment is rich in oppositions as are all times of transition. The intellectual life of the period reflected all colors and nuances.*

As Kathleen Grange (1961) demonstrates the area of the passions and affections was not forgotten during this period. Philosophers as well as poets and authors wrote of them but it was the latter groups that showed themselves possessed of knowledge in the subject.

The introduction of the concept affective or moral insanity should be placed in the context of this trend towards growing insight into the significance of the emotional side of man's existence. It reflects a tendency of the period, but is also to a high degree a result of empirical research (cf. Carlson & Dain 1962, pp. 131 ff.). In confrontation with reality traditional rationalistic definitions of mental disorders proved to be inadequate. The "madman" could hardly be characterized only by odd ideas, confused speach and the like, indeed in many cases it seemed to be almost solely his emotional life, drives and behavior which deviated from the ordinary and accepted.

This new insight was to have important consequences for psychiatry. The sharp boundary between normality and "madness", between mental health and illness which earlier definitions had set up were erased to an increasing extent, while a large border area appears, "as rich in shifts and as undefined in width as the area between colors of the spectrum" (Gadelius 1896, p. 3).* It is from this border area that contemporary concepts such as neuroses, psychopathy, behavior disturbances, etc. have derived (cf. Dain & Carlson 1962, p. 795).

A few additional explanations are perhaps necessary. "Partial insanity" was a concept which developed during this period in which the rationalist interpretation of "derangement" dominated, so that fundamental even for this kind of madness, most often given the name melancholy, was not the affective abnormalities but rather disturbances of understanding or reason (delirium).

The concept "affective insanity" grew up in opposition to the traditionally conceived idea of "madness". We find for example in the work of Pinel (see section 2.4.2, below), the forms mania and melancholia (as well as dementia and idiocy, also these characterized by disturbances or inadequacies of the intellectual area), but in contrast to these something new is asserted: mania *without* delirium, that is a disorder without any sort of singular reasoning, hallucinations or delusions.

With Prichard (see section 2.6.1, below) this relationship is further marked. He speaks of "*intellectual* insanity" with subdivisions "monomania or partial insanity", "mania" and "incoherence or dementia", but in contrast to these he also has "*moral* insanity" (italics mine), a condition "without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination" (Prichard 1835, p. 6).

How did the concepts partial and affective insanity come to be confused? One of the most important reasons seems to be that French psychopathology, headed by Esquirol (see section 2.5, below), made "affective insanity" a variant of "partial insanity". The latter was called "monomania", and affective insanity therefore considered to be one of the monomanias.

Another contributing factor was probably that the legal consequences of both of these two disease categories were to a great extent the same. "Partial insanity", "monomania" and "moral insanity" made up concepts which in the animated controversy on imputability came to be equivalent.

Finally, one must also consider that reality itself, that is to say the multiplicity of the patients' symptoms, refused to subordinate itself to a system of classification basically founded upon an arbitrary dividing of mind into separate faculties done by armchair psychologists.

2.3 The Meaning of the Term "Moral"

The word moral (Fr. *moral*, Ger. *moralisch*, Sw. *moralisk*) has played an unusually prominent role in the history of psychiatry. Not least when combined in "moral insanity" the term has provoked lively debate. Much of the confusion

which characterized the discussion of "moral insanity" for more than a half century after Prichard (1835) introduced the concept was tied to an unclear idea of what was meant by the attribute "moral".

As we know, "moral" comes from the Latin *moralis*, referring to what was called *mores*, customs. This etymological link remained valid during the 18th and 19th century, the problem arising when the adjective at the same time was given several secondary meanings.

Schrenk (1973) has made an attempt to trace the philosophical ideas concealed behind different authors' use of the term moral during the years around 1800. He found that the moral sense philosophy had a certain influence, but there is also another connotation, going back to Montaigne's non-evaluative concept *science morale*. This concept "concerns nearly everything—disregarding the merely physical—that relates to man" (p. 126).*

It is in this wide, non-evaluative sense that the word moral is used when authors refer to the *physical* and *moral* sides of man's "double nature". For example Cabanis uses the term in this sense in the well-known *Rapports du physique et du moral de l'homme* (1802).

A closely related connotation is to be found in the works of Pinel, who employs the attribute in the name of his method of treatment, *traitement moral*, which comprehends all those influences which were not medical in the limited sense of the word. Reil and Langermann use *psychische Curmethoden* to translate the French term (Schrenk 1973, p. 119). In present-day language "moral" in the combination *traitement moral* most closely approximates the expression "psychological".[19]

Considering the strong tie between *traitement moral* and Pinel, distinguished for his humanitarian contributions, one might wrongly assume that "moral treatment" was equivalent to "humane treatment". That this is not the case is easily realized when one considers that the most violent sorts of shock methods were found on equal terms with dialogue, entertainment and work under the heading *traitement moral*.[20]

We should bear in mind, however, that for Pinel "moral" has also a more limited significance, as Grange (1961) demonstrates. Pinel believed that the

[19] Walk (1954) believes that the English "moral" in the meaning "psychological" is a gallicism, "for up to the translation of Pinel's work, treatment other than medical", that is, that which, as we have seen, had then began to be called "moral treatment", "is always called 'management'" (p. 809).

[20] Cf. e.g. Reil (1803, p. 25). *Psychische Curmethoden* was his term for all therapeutic aids which influenced the powers of mind so that a change in its organization was brought about resulting in mental health. Among these aids Reil included the stimulation of fear in the mentally ill, which could be accomplished for example by firing off a canon or the sudden shock of an ice bath. However, further into the 1800s "moral treatment" was increasingly coupled with humanitarian psychological and occupational therapy. By the middle of the 19th century it had enthusiastic support, especially in the USA. Cf. section 2.6.2, below.

primary causes of mental illness were those he called the moral, and his clarification on this point shows that it was above all the affective reactions he had in mind. Moral treatment was intended among other things to stimulate certain feelings, and was based on classical theories of a balance between the passions.[21] With the stoics, for example, the passions played a central role in an explanation of disturbances of the mind.

During the period under discussion it is possible to discern another nuance in the word moral. At the beginning of the 1800s it became increasingly common that the psyche was divided into those three categories which are now so familiar: intellect, passions, will.[22] When Prichard (1835) proposed his concept moral insanity he stated that he did not wish to separate the emotional and active sides of the mind, since "propensities - - - are so nearly allied to passions and emotions, that they are generally referred to the same division of the faculties or of mental phenomena - - -" (p. 10). Supporting his position he refers to the "metaphysicians", that is, the philosophers who, according to him, allow the emotions and will to be included in "the ethical or moral department of the mind, as distinguished from the intellectual" (ibid.).

We have then determined the following nuances of meaning in the term moral:

1) ethical;
2) affective, emotional, assigned to the passions or feelings;
3) referred to the passions and will—the character side of the personality;
4) indicating the mental side as a whole; "psychological" in its widest meaning.

Of course the authors under discussion would not have been especially aware of the boundaries between connotations set up by an analysis of this type. For them the word moral probably shifted in meaning from one moment to another. In Prichard's work for example one finds with "moral" that emphasis is placed first on one nuance, then another, depending on the context of the term.

Considering the distorted understanding of Prichard's moral insanity concept often shown by present-day authors, a repetition is perhaps appropriate: "moral" in the combination "moral insanity" designates, according to Prichard's own definition the emotional and conative side of the psyche, as opposed to the intellectual. That moral insanity as illness expressed itself among other things in

[21] Cf. Grange 1961, p. 443; Pinel 1906, pp. 228 ff.

[22] The division into understanding, will and emotion is said to have originated with the Holsteinian philosopher and later Danish civil servant Johann Nicolai Tetens (1736–1807), and in accordance with the spirit of the times signified a confirmation of the emotions as an important aspect of the mind. This trinary division rapidly became popular, at least in nations dominated by German philosophy, primarily because Kant employs it in his *Anthropologie* (1st ed. 1789). See e.g. Schinz 1906, pp. 1 ff.; Flugel 1959, p. 14.

In the psychiatric classifications of the time the division was utilized by, among others, Heinroth, who in *Lehrbuch der Störungen des Seelenlebens* (1818) built his entire system on it. In France Esquirol distinguished between intellectual, affective and instinctive monomanias, but for the most part followed Pinel's groupings.

morally deplorable actions is not denied—on the contrary—but that is not the fact motivating Prichard's choice of name for the diagnostic category he instituted.[23]

2.4 Two Prominent Figures

2.4.1 Rush: Disease in the Moral Faculty

In 1786 the American physician Benjamin Rush (1745—1813) published an essay entitled *The Influence of Physical Causes upon the Moral Faculty*.[24] It is of great interest in the present context since it contains what is, as far as I have been able to ascertain, the first extended discussion of certain—according to the current moral view—reprehensible actions as expressions of illness. Here we have in fact the first tentative attempt to delimit those phenomena which will later be called "psychopathic".

The essay is also of interest in other respects for it illuminates various aspects of the intellectual world in which the physician of the late 1700s functioned. We see the mechanistic view of man, going back to Descartes and the iatrophysics of the 17th century, also the contemporary faculty psychology with its artificial lines of division and pseudoproblems. The humanitarian side of the Enlightenment is represented, as are reservations over the claim of theologians and philosophers to be the specialists of the mind.[25]

[23] It is interesting to note that as early as the end of the 19th century historically knowledgeable psychiatrists had pointed out this misinterpretation of the term moral. In 1899 Müller wrote (p. 326 f.): "The author (Prichard) sets up 'moral insanity' against intellectual insanity and thus makes a similar division as Esquirol. The term 'moral' in the combination 'moral insanity' corresponds to the word 'affective' used by Esquirol".* Müller further claims that the common mistake of translating "moral" into *moralisch*, i.e. "ethical", is a mistake dependent on the double meaning of the term. Kraepelin (1915, p. 2106) is also quite clear about this. Nevertheless the misconception lives on (cf. note 50, below).

[24] The essay was a printed version of a lecture given by Rush before the American Philosophical Society in February, 1786. There was a great demand for the pamphlet which was published in a second edition that same year. It also came out in London but did not sell as well there (see Carlson & Simpson 1965, pp. 23 f.). According to Butterfield (1951, p. 378) this pamphlet is Rush's "most important philosophical paper and a landmark in the development of psychiatry as a science". It is indeed surprising that so few of the earlier accounts of the history of the psychopathy concept have contained mention of this essay by Rush. Most of them, including the American, find the first vague attempt to delimit the concept of psychopathy to be that of Pinel (1800/01).

[25] Rush's essay can also be seen as a contribution to the battle between physicians on the one side and theologians and philosophers on the other as to priorities in research and treatment of "madness". It was far from clear at the end of the 18th century that this was an area of medicine. Nor was "madness" generally considered to be an illness. Accordingly, both Kant and Hegel wrote treatises on the subject, and the German psychiatric author J.C. Hoffbauer, much cited at the beginning of the 19th century, was not a physician but a philosopher. As late as 1818 Heinroth discusses whether the "art of psychic healing" (*die psychische Heilkunde*) should be undertaken by physicians or practitioners of other trades: "Is the province under discussion a matter for the doctor? Or perhaps, if anything, for the clergy? Or the philosophers? Or the educators? Each of these four classes has a ground, or at least an apparent right to incorporate and study this health-promoting profession" (Heinroth 1818, vol. 1, p. 43).*

Rush points out that medical literature contains many descriptions of how physical phenomena can injure the judgement, ability to remember, to imagine, etc. According to him such cognitive disturbances have been rightly referred to the physicians' area of competence. But even the moral faculty can, he claims, be influenced by physical conditions, so that disturbances arise; logically even these should fall within the sphere of medicine (see Runes 1947, pp. 183 ff.).

The author gives several examples of cases of moral derangement.[26] That which is cited here is clearly in the nature of an anecdote, but is immediately interesting not as such but as an instance of Rush's reasoning on this form of "illness". He writes (ibid. p. 184):

> The celebrated Servin, whose character is drawn by the Duke of Sully, in his memoirs, appears to be an instance of the total absense of the moral faculty, while the chasm produced by this defect, seems to have been filled up by a more than common extension of every other power of his mind.

This Servin[27] was a fantastically knowledgeable and accomplished individual. He spoke many languages, was master of philosophy, mathematics, theology, and could deliver an outstanding sermon—if he so wished. He had dramatic talents, wrote poetry and played different musical instruments; he was an athlete, an excellent rider and dancer. However, at the same time he was grim, false, a coward. He lied, deceived, drank and had every conceivable vice. Appropriately enough he died in a brothel with a glass in his hand, blaspheming.

According to Rush the character sketch he draws has not been earlier seen as reflecting disease but vice. Thus it has not appeared in any nosology, despite the intensive preoccupation of contemporary medical theoreticians with such systems.[28]

Rush himself terms the total absense of moral faculty *anomia*, while a partial or weakened action of it is given the name *micronomia*.[29] Here we have some of the

[26] It should be observed that unlike most of the other authors mentioned here, Rush employs the word moral primarily in its ethical sense. Cf. section 2.3, above.

[27] He is described by the French statesman Maximilian de Bethune, Duke of Sully (1560–1641) advisor and good friend of Henry of Navarre.

[28] Beside the speculative medical systems (of Hoffman, Cullen, Brown, etc.), so typical of the 18th century, a number of attempts were also made to classify diseases in accordance with the "natural historians' " systematization of vegetable and animal life. Carl Linnaeus (1707–78) was one of these nosologists. Regarding his views it has been said: "This eminent botanist believed indeed the relationship between symptoms and disease to be the same as that between leaves, tendrils and plants: 'Symptomata se habent ad morbum ut folia et fulcra ad plantam' " (Riese 1945, p. 467). This latin sentence is certainly found in Linnaeus' work (cf. Schröder 1759, p. 6) but keeping in mind his rich and figurative language, it might well be metaphorically intended. The bestknown of nosologists was François Boissier de Sauvages (1706–67), who divided diseases into 10 classes, 40 orders and 78 families (Veith 1958, p. 388). In this area Linnaeus was preceeded by de Sauvages. He considered the latter's system to be "uncomparable in natural arrangement and inner perfection" (Fåhraeus 1970, p. 154),* and his own system was an attempt to improve the classification of de Sauvages.

[29] Rush abandons these diagnostic terms in *Diseases of the Mind* (1812). Here he speaks instead of "moral derangement", in accordance with the following declaration: "In inquiring into the causes of the diseases of the mind, and the remedies that are proper to relieve them, I shall employ the term derangement to signify the diseases of all the faculties of the mind" (Rush 1827, p. 9).

first examples of that long line of medical terms which will replace each other over a period of almost two hundred years (cf. appendix, below).

It is obvious that in this essay Rush treats a subject that was controversial, not least from the point of view of theology. It is possible too to see how carefully he maneuvers, how he guards himself by citing the Apostle Paul and so on. The philosophical problem he touches on—man's ability to distinguish between right and wrong and his freedom to choose—did indeed interest him deeply (cf. Carlson & Simpson 1965, p. 23).

In his major work, *Diseases of the Mind* (1812), Rush attempts to explain how a physician might be able to distinguish between a free, morally responsible act and that which is not free, but sick. He emphasizes the difficulty of such a task, but in principle the will is diseased "when it acts without a motive, by a kind of involuntary power" (Rush 1827, p. 261). The image he invokes to assist in explaining the relationship is illuminating for his faculty psychology (ibid. p. 261 f.):

> Exactly the same thing takes place in this disease of the will, that occurs when the arm or foot is moved convulsively without an act of the will, and even in spite of it.

Benjamin Rush was a prominent man in the America of his time, one of those who signed the Declaration of Independence in 1776. He was a passionate philanthropist and campaigned for a many social, penal and pedagogic reforms. Among other things he fought against slavery and capital punishment. His humanitarian pathos embraced even the psychically ill, and it is primarily for his battle to improve their situation that he has been given the title "the father of American psychiatry".[30]

2.4.2 Pinel: Mania without Delirium

If opinions have been divided concerning the significance of Rush's psychiatric thought, they are all the more unanimous regarding Pinel, who is definitely one of the great men in the history of psychiatry. He is most famed perhaps for allowing a number of shackled inmates to be freed from their chains during his time at the institution Bicêtre in Paris.

Thanks to the Revolution Philippe Pinel (1745–1826), a discreet but knowledgeable and well-read doctor from the South of France reached the highest positions in his field. He was appointed chief physician for Bicêtre in 1793 and would later work for many years at the equally well-known Salpêtrière.

[30] Shryock (1944/45, p. 429) asks himself: "To what extent does he (Rush) deserve the title 'Father of American Psychiatry'?" He finds that—although his contributions as a physician are still the subject of debate—it is undeniable that he was a pioneer in the area of psychiatry in America, and that he fought for relatively humane methods of treatment and the development of good institutional care: "On the whole, his psychiatry anticipated a modern orientation, while his general medicine looked to the past" (ibid. p. 432).

One may feel with Riese (1951, p. 314) that in revolutionary France where, for the first time in history, the *little* man was made a full citizen (*citoyen*), "lunatics" would no longer languish in chains, but sympathy did not extend that far. According to tradition it was the notorious Couthon himself, the feared leader of the Paris Commune and one of Robespierre's closest associates, who once visited Bicêtre and inquired as to whether Pinel himself was not mad, letting all the "wild beasts" run free.

Pinel's work of liberation has however been overly dramatized and its historic significance exaggerated.[31] Similar humanitarian measures were also carried out at this time in Italy (Vincenzo Chiarugi 1759–1820; cf. Mora 1959), in England (William Tuke 1732–1822) and somewhat later in Germany (J.G. Langermann, 1768–1832).

Historians tend to see Pinel's striving to develop a well-functioning hospital organization as the decisive contribution to the continued development of psychiatry. "It was only after the madhouse became a hospital—the greatest single step in the history of psychiatric medicine—that the psychotic could be studied and treated effectively", write Alexander & Selesnick (1966, p. 112).

Pinel was perhaps best known to his contemporaries as author of the massive *Nosographie philosophique* (1st ed. 1789), in which he handles all sorts of ill-

[31] For over a century and a half historians of psychiatry have uncritically passed on the romanticised view of Pinel as the great liberator of the shackled "lunatics" (cf. Zilboorg & Henry 1941). There has been no actual source research on Pinel and his work until recently. The information earlier referred to was primarily taken from the writings of the psychiatric historian René Semelaigne, a descendant of Pinel. His work is strongly panegyric and based on a tendentious depiction of history that had begun during Pinel's own lifetime, in which an attempt was made to show that progress in psychiatry took place only in the post revolutionary era, while all ward before that time was painted in dark tones. In a work from 1971 Jetter has shown that mild methods were employed before the revolution at for example the Hôtel-Dieu in Paris. Reading Zilboorg & Henry (1941, pp. 319 ff.) one gets the impression that with one mighty blow Pinel freed the mentally ill from their chains. This was hardly the case. He was actually very selective in deciding which patients should be chosen for this new measure. At a later date most of the patients were set free, but as late as 1809 physicians visiting Pinel's wards witnessed the use of shackles.

Was it actually so that with his now so famed measure Pinel had purely humanitarian motives, acting on the belief that force and chains were damaging measures to be taken in the care of "lunatics"? Riese (1951, pp. 315 ff.) implies another motive. Pinel had been greatly impressed by Hippocratic medicine. It was characterized by a conscious striving to observe the entire course of a disease, to avoid interference and preferably to support the natural healing process. Pinel also strove to study and describe the "natural history" of diseases. According to him different sorts of treatment always disturbed the natural course of the disease. "It is tempting", writes Riese (ibid. p. 317), "to assume that this significant element of Hippocratic medicine, combined with a compassionate nature, stimulated him to make the step establishing his fame, namely the liberation of the insane from their fetters as from a 'treatment' responsible for violent and ferocious behavior". Riese's point of view is not incompatible with the following statement of Pinel (cited in Zilboorg & Henry 1941, p. 341): "How were we to distinguish between the exasperation caused by the chains and the symptoms peculiar to the illness?".

The above information has been taken primarily from Jetter (1971). Also used were Ellenberger 1970a, pp. 27 f., 33 f.; Riese 1951; Woods & Carlsson 1961. For a more realistic view of Pinel and his work see also Raymond de Saussure (1956).

nesses, and in the spirit of the nosologists attempts to draw up a general classification of diseases. The work came to play a certain role during the first decades of the 1800s. What interests us here is, however, Pinel's classification of and his opinions on what he called *aliénations mentales*.

In his famed dissertation *Traité médico-philosophique sur l'aliénation mentale ou la manie*[32] Pinel presents five nosological units: melancholia, mania without delirium, mania with delirium, dementia and idiotism.[33] Considering his earlier documented weakness for classifications, this is a remarkably simple division. It is primarily a return to a classical prototype.[34] It was, however, fully sufficient for the scientific and organizational demands of the period. The medical historian Veith (1957, p. 388) claims that Pinel was the first "who combined a broad intellectual background with sufficient clinical experience to arrive at a workable psychiatric nosography".

Pinel was himself aware that his division only functioned as a temporary aid, but he commented: "I do not believe that medical science is sufficiently advanced to allow of any change in the classification I introduced" (cited in Zilboorg & Henry 1941, p. 327).

What is new in Pinel's division is his diagnostic category *manie sans délire*,

[32] There is a certain amount of disorder in the details of the history of Pinel's famed *Traité*. Some date the first edition to 1800 (e.g. Beyerholm 1937, p. 188), but most authors consider it to have come out in 1801. The disagreement results from the book being published while the so-called revolutionary calendar was in use; according to it the book was published in the year IX. This year extended from 22 september 1800 to 21 september 1801. There is also disagreement regarding the editions. Usually the edition of 1800/01 is considered to be the first and the much reworked edition of 1809 the second. However, Zilboorg & Henry (1941, pp. 329–341) have long citations from what is identified as the first edition. These are not found in the edition of 1800/01. According to Grange (1961, p. 444, note 10) Pinel had completed a manuscript on mental disorders as early as 1788, and the foreword to the so called first edition reprinted in the 1809 edition – the foreword probably cited by Zilboorg – should then be the foreword to the 1788 manuscript.

[33] He speaks in somewhat more detail of a) Melancholia, or delirium upon one subject exclusively; b) Mania without delirium; c) Mania with delirium; d) Dementia, or the abolition of the thinking faculty; e) Idiotism, or obliteration of the intellectual faculties and affections (Pinel 1806, chapter headings). I have cited the contemporary English version of Pinel's work, despite the fact that this sometimes does violence to the original; I have, however, also checked my citations against the French original to be sure the sense has been preserved.

Just as the term delirium (cf. section 2.2, above) has a different content today than it had around 1800, so did mania have a different meaning at that time. In its vaguest form "mania" was identical with "madness" (cf. the title of Pinel's *Traité médico-philosophique sur l'aliénation mentale ou la manie*, 1800/01). Pinel uses *délire géneral* as a synonym for *manie* (Pinel 1809, pp. 139 ff.). To be more precise, "mania" did not at that time only refer to manic exaltation but implicated also confusion, incoherent speech, hallucinations, etc.

[34] One finds in Hippocrates a classification of mental disorders into: mania, melancholy, paranoia and epilepsy. Paranoia then meant something like "mental deterioration" (see Zilboorg & Henry 1941, p. 47; cf. the etymology of the word, fr. Gr. *para'*, beside and *nous*, reason). With Galen we find a further categorization. In addition to mania and melancholia he speaks of *amentia*, corresponding to dementia; and *stultitia* or *fatuitas*, corresponding to imbecility and idiocy. Apart from Pinel's binary division of mania, then, he follows the antique system entirely, though of course he has a more differentiated comprehension of *mentis alienatio*, or as Pinel wrote *aliénation mentale*.

later also to be called *manie raisonnante* or *folie raisonnante* (cf. Campagne 1869, p. 51). It was no occasional whim that moved him to introduce this concept. He writes of how it happened (Pinel 1806, p. 50):

> On resuming at Bicêtre my researches into this disorder (mania), I thought with the above author (Locke), that it was inseparable from delirium; and I was not little surprised to find many maniacs who at no period gave evidence of any lesion of the understanding, but who were under the dominion of instinctive and abstract fury, as if the active faculties alone sustained the injury.

Thus through his own empirical studies Pinel discovered what was inadequate, even incorrect in the old view of "madness" as a basically intellectual disturbance. Through the introduction of his new disease category he advocates another way of seeing, that would within a century culminate in Freudian psychoanalysis, namely that there are grave psychic problems that are basically emotional in nature.

What then are those symptoms Pinel gathers together under the heading *manie sans délire*? Luckily he gives a few examples in his book, even if the descriptions of these are such as to leave room for speculation. One of the cases which is especially interesting from our point of view has often been cited in the literature and is therefore given here at length (ibid. pp. 151 f.):

> An only son of a weak and indulgent mother, was encouraged in the gratification of every caprice and passion, of which a violent and untutored temper was susceptible. The impetuosity of his disposition increased with his years. The money with which he was lavishly supplied, removed every obstacle to his wild desires. Every instance of opposition or resistance, roused him to acts of fury. He assaulted his adversary with the audacity of a savage; sought to reign by force and was perpetually embroiled in disputes and quarrels. If a dog, or a horse, or any other animal offended him, he instantly put it to death. If ever he went to a fete or any other public meeting, he was sure to excite such tumults and quarrels, as terminated in actual pugilistic encounters, and he generally left the scene with a bloody nose.
>
> This wayward youth, however, when unmoved by passions, possessed a perfectly sound judgement. When he came of age, he succeeded to the possession of an extensive domain. He proved himself fully competent to the management of his estate, as well as to the discharge of his relative duties; and he even distinguished himself by acts of beneficence and compassion. Wounds, law-suits, and pecuniary compensations were generally the consequences of his unhappy propensity to quarrel.

Finally a deed of violence set a stop for his progress and he was placed in Bicêtre.

Kavka (1949, pp. 464 f.) comments on the case in the following words:

> We are informed of the etiologic importance of poor guidance or education on a constitutionally inadequate ("a mind naturally perverse and unruly") person, resulting in psychopathy. - - - Certainly, this capsular history is gravely inadequate for serious use as an example of any clearcut disorder, yet one is generally impressed that the patient is the overprotected "enfant terrible" who is essentially neurotic or suffering from a neurotic character disorder. In the absence of more conscientious descriptions, one cannot entirely preclude the existence of a basic psychopathic state.

Thus the above citation seemingly indicates that Pinel has actually drawn attention to a syndrome which was later designated as psychopathy. However, his two other examples of *manie sans délire* shows with desired clarity that his diagnostic concept was considerably more comprehensive than its contemporary equivalents. Kavka (ibid.) judges the latter examples as constituting cases of epilepsy equivalent and of paranoid schizophrenia. Common in all three cases is a violent, uncontrolled emotion.

2.4.3 The Contributions of Rush and Pinel: A Comparison

It is often difficult to decide priority in questions of scientific ideas, discoveries or the like. Often two similar approaches will appear almost simultaneously, without any relationship between them beside the fact that the authors have been influenced by the same spirit of the times. A familiar example is the idea of evolution, found in the work of several of Darwin's contemporaries.

With respect to the origin of the psychopathy concept many researchers have almost routinely referred to Pinel and his *manie sans délire*. On the other hand Rush is named far less frequently (cf. note 24, above).

There is no doubt that it was Rush who, earlier than others, described a condition of a nature that would later come to be called psychopathy. His ideas and observations are, however, presented in such a form as to have no future, and they were passed over in favor of pace-setting French psychiatry. Rush did not found a school, as did Pinel, and he had no dynamic follower to carry his work further. He stands as a rather isolated figure in the history of American psychiatry with neither predecessors nor followers with any notable profile. After his death it remained silent on the American psychiatric front for several decades.[35]

Pinel's place in the history of the psychopathy concepts is quite another one. His *manie sans délire* resembles our present-day concept of psychopathy far less than does the "disease in the moral faculty" or "moral derangement" of Rush, but it is the starting point for a development that would in fact lead to precisely those concepts. The extent to which Rush's thought influenced developments is far more unclear. However, it can be assumed that psychopathologists of the early 1800s were relatively well acquainted with his ideas, since his *Diseases of the Mind* was printed in five editions in English—the last in 1835—and was also translated into German. The German translation was in turn rendered into Swedish in 1827. Additionally, Rush is cited by authors such as Esquirol, Prichard and Ray (see section 2.5, and note 40, below).

[35] "Until the forties of the century no one reached the stature of Benjamin Rush - - -", writes Zilboorg (1941, p. 410). Shryock (1944) points out that American institutions had a number of quite competent superintendents during the 1830s and 40s, but "in so far as they were concerned at all with questions of etiology, classifications and methods of treatment, they tended to follow British and French leadership" (p. 22).

Pinel does not seem to have been aware of Rush when he wrote his *Traité* (1800/01). At least there is nothing in that work to indicate that he was acquainted with the ideas of his American colleague. Rush on the other hand often cites Pinel in his work from 1812, but by then his idea of a disease of the moral faculty had as we have seen already been formed.

Rush and Pinel had of course much in common. Born in the same year, they received a medical education which had much the same content. Both were for example influenced by William Cullen (1712–1790).[36] Both were greatly impressed by the ideas of the Enlightenment. But there were also many differences between the two. Pinel worked within a secularized and even anticlerical tradition, whereas Rush was always a believing Presbyterian. These different backgrounds left traces in their psychological conceptions.

Rush was for his part influenced by Scottish philosophy and its positive attitude towards religion. His psychology is similar in many ways to that of the moral sense school (cf. Segerstedt 1937). In his essay of 1786 he also names several of the representatives of that school, Shaftesbury and Hutcheson. Among the faculties of the mind Rush includes "understanding, memory, imaginations, passions" and "will", as well as "the principle of faith, the moral faculty, conscience, and the sense of Deity" (Rush 1827, p. 8). It was on the basis of this psychology that he created his nosological groups. The result seems in our eyes to be a very artificial classification, which obviously found no real response from his contemporary colleagues either.

Pinel's psychology was colored by English empiricism, as it had been further developed in France. The philosophical authorities most often referred to in his *Traité* are John Locke and Condillac. The extreme sensationalist psychology of the latter would admit of no inborn faculties of the mind, and even if Pinel did not accept Condillac's thoughts uncritically, he is still sensationally oriented.

For Pinel it seemed natural to classify mental disturbances by symptom and syndrome, in accordance with classical medical principles. Because of this he seems today to be more modern than Rush, for contemporary psychiatry works after much the same principle.

However what is important here is that Pinel's psychiatry—and consequently also his observation of a mania without demonstrable intellectual disturbances—is the starting point of the influential French School which was to dominate psychopathology until the 1860s.

This influence was not undeserved. That Pinel was a man of science more prominent than Rush can hardly be debated. The work of the latter is clearly rooted in the rationalistic system thinking of the 18th century, while Pinel, at least

[36] Rush took part of his medical training in Edinburgh as a pupil of Cullen. Pinel was also well acquainted with Cullen's medical theories and even translated a number of his writings into French.

in what concerns psychiatry, is much more of an empiricist.[37] The American uncritically refers to the cases of older authorities, and his idea of a moral derangement was at least to begin with a pure product of cerebration, a result of his psychology combined with his general medical philosophizing. Of course, Pinel also begins with certain theoretical suppositions on mental disturbance, but he works empirically and this leads to a revision of theory on the basis of observation.

2.5 Theory of Monomania

The most prominent of Pinel's students was J.E.D. Esquirol (1772–1840). He came to Salpêtrière in 1799 and worked there under Pinel. In 1817 he began a regular clinical instruction in psychiatry and in 1825 was appointed chief of another institution, *Maison de Charenton* outside Paris which, under his supervision, became somewhat of a model for its time. Indeed, Jetter (1971) claims that Charenton had a greater significance for the development of practical psychiatry in Paris than the more well-known Bicêtre and Salpêtrière.

In his work *De la folie* (1816) Esquirol enriches Pinel's classification with a new concept: monomania.[38] He was initially sceptical of Pinel's idea that there might exist manias without intellectual disturbance, but subsequent experience moved him to change his opinion (see Esquirol 1838, vol. 1, p. 378).[39]

[37] Regarding Pinel's medical theories there is no lack of criticism among medical historians of today. His liking for classifications is emphasized, though he himself expressly dissociated himself from his predecessors in the genre. He certainly participated in the revolution against the old rationalistic medicine practised in Paris and he stimulated the research of the prominent physiologist Bichat, "but Pinel was far too much a bookman and a naturalist to carry through the medical revolution. - Only in a relatively virgin field like psychiatry could real progress still be achieved with his antiquated methods" (Ackerknecht 1953, pp. 334 f.; cf. also Sigerist 1944, p. 33). Woods & Carlson (1961) are more positive. They explain his influence thusly: "He worked in Paris, wrote in French, and made a name for himself with his *Nosographie philosophique*. In addition, he trained a generation of successors who carried on his fame" (p. 18, note 11). Regarding Rush as a medical theoretician see note 30, above).

[38] The actual term monomania existed earlier. I have for example noted its use by Linnaeus (1907, p. 236).

[39] The quesiton of isolated affective derangement is illuminated by Esquirol's reasoning on Pinel's *manie sans délire*. He writes (Esquirol 1833, vol. 1, p. 334): "In Pinel's *manie raisonnante*, in *manie sans délire*, the intellect is more or less injured. If this was not the case, the insane would allow themselves to be governed by reason and admit that their principles were false, that their labor was meaningless, their actions bizarre. The intellect is more or less on the wrong track, it has lost its influence over the will and finds itself no longer in harmony with the other faculties. With the insane, who without notice allow themselves to be instinctively pulled along in reprehensible actions which would be criminal if they still had possession of their reason, the activities of the intellect are suspended. In these cases careful examination would show a lesion of the understanding (*lésion de l'étendement*), but this injury is not the dominating cause of their actions".*

Clearly central in Esquirol's thought is that the affective disturbances in these monomanias is primary and does not, as had been thought earlier, result from intellectual disorders. Through violent, occasionally perverted passions and inclinations the power of reasoning, healthy in itself, is overridden and consequently its ability to control the affective-conative side of the personality is incapacitated.

Though the concept of monomania certainly encompasses the observations and the psychological viewpoint behind Pinel's *manie sans délire*, if seen formally Esquirol's new diagnostic group is a further development of the old concept partial insanity (cf. section 2.2, above). During this time partial insanity was, as stated earlier, almost synonymous with melancholia. However, Esquirol disliked the term melancholia, which for his contemporaries still maintained its etymological content, thus indicating that the illness in question was etiologically related to the bile (melancholis, fr. Gr. *me'las*, black, and *chole'*, bile).

Prichard (1835) considered that Esquirol also reacted against the fact that the term melancholy "suggested the idea, not always consistant with facts, that partial derangement of the understanding is essentially of a gloomy character, or connected with sadness and despondency" (p. 26). Crucial for partial insanity was, however, not the depressive symptom picture but rather the fixation on a specific idea or group of ideas which can be said to constitute the nucleus of the illness. Ideas of inadequacy and sinfulness were certainly related to depression and despair, but on the other hand there are ideas just as fixed and circumscribed that are accompanied by an elevated emotional state, for example delusions of grandeur.

Esquirol made a further distinction: he termed depressive partial insanity *lypemanie*, while the other types were *monomanie*. The former term never really caught on as did "monomania", the influence of which can be traced in such names as pyromania, erotomania etc., all of which were considered to be special forms of monomania.

The theory of monomania is presented in detail in Esquirol's psychiatric "testament", *Des malades mentales* (1838). Like Heinroth (1818) he starts from the division of the mind into understanding, will and feeling. When the imagination or understanding is attacked, he speaks of it as *monomanie intellectuelle*. This group seems much like the old partial insanity which was, as we know, characterized by a circumscribed cognitive disorder. When the will is struck we have a *monomanie instinctive*. The victim is forced to act in a manner contrary to his own wishes, since the will is diseased and consequently sets its own course.[40] With the third group of illnesses, *monomanie affective*, it is the emotions that are attacked. The affections are too strong or "perverted" and therefore distort behavior (Esquirol 1838, vol. 2, p. 332). Pinel's case of *manie sans délire* would belong primarily in the final category.

Esquirol does not, however, limit himself to these categories but also names monomanias after the dominant idea or the action that the partially insane is driven to perform. Therefore we learn of *monomanie érotique, monomanie*

[40] Cf. Rush's reasoning, section 2.4.1, above. Esquirol (1838) refers to Rush on several occasions and therefore was not unacquainted with his position. It is even conceivable that he had been influenced by Rush and his "derangement in the will" when he formed his idea of *monomanie instinctive*, that is, monomania in the area of the will. Cf. Rush 1827, pp. 261 f.

d'ivresse, monomanie incendiaire, monomanie homicide, monomanie raisonnante, etc.

Through this looseness Esquirol had already revealed one of the great weaknesses in the theory of monomania: it led to "a richness of forms that so obligingly bent in imitatio of nature that almost every superficial symptom led to a new category of cases" (Gadelius 1896, p. 17).* "The most typical expression of this trend" writes Herrlin (1904, p. 134) "is perhaps Trélat's *La folie lucide* (1861), a collection of disease histories gathered under titles such as Satyrs and Nymphomanes, Erotomanes, Jealousy, Dipsomanes, Wasters and Adventurers, Prideful, Mean, Kleptomaniacs, etc".*

The theory of monomania soon spread throughout France, and the prominent psychiatrists of the time contributed descriptions of cases and new varieties of monomania. It can be considered a step forward compared to earlier nosologies, but still did not go without being contradicted.[41]

As early as 1819 J.P. Falret, one of Esquirol's students, objected to the idea of partial insanity and stated that the mind is not divided into faculties which function independently of each other. During his entire long psychiatric career he continued to criticise the theory of monomania (cf. Falret Sr, 1864, pp. 425 ff.).

In the *Société médico-psychologique* in Paris the question was also the subject of lively debate for many years (see Gadelius 1896, pp. 26 ff.).

Much of the debate on the concept of monomania was concerned with the position of the monomaniac in relation to criminal law. This question engaged French psychiatrists greatly during the 19th century, and naturally jurists as well.[42]

[41] In their historic review of the development of psychiatry during the 19th century Magnan & Legrain (1895, pp. 2 ff.) maintain that the theory of monomania was definitely profitable for psychiatry. It led to an intensive empirical psychological study of the psychopathological conditions, which would be of benefit to future psychiatrists. Of course it was not without good reason that this theory was accepted by men so prominent in the history of psychiatry as Parchappe, Renaudin, Baillarger, Calmeil, Trélat, Moreau de Tour, Marcé, Dagonet, Tartieu, and Laseque. Cf. also ibid. pp. 15 f.

[42] Among those who were engaged in the question on the judicial position of monomaniacs earliest and with most energy was E.J. Georget (1795–1828), one of Esquirol's most gifted pupils. He considered "mental alienation" to be a uniform idiopathic brain disease, despite the variety of disparate symptoms. This did not, however, prevent him from defending the concept of monomania. Cf. Georget (1820).

The theory of monomania did in fact influence a number of forensic theoreticians who labored with "partial imputability" in accordance with the approach. It should be observed that the concept of reduced responsibility which is used in the laws of many nations is quite different. Herrlin describes the impossibilities to which the concept of partial responsibility could lead to in extreme cases (1904, pp. 179 f.):

"A *kleptomaniac*, who *steals* is according to the theory of partial imputability unaccountable for his *thefts*, but fully accountable for other delicts such as murder, which do not result from his 'monomania'. Unimputability then is of relevance only in the case of certain specialized actions, and in their case without restriction. On the other hand an individual who is given reduced punishment because his acts are a result of imbecility, senile debility, etc. has been treated according to the theory of reduced responsibility. In this case no consideration is given to the special nature of the delict, only to the general reduction in the universal faculties of the delinquent - - -".*

Regarding *monomanie homicide*, that is the unexplainable drive to murder, Esquirol writes (cited after Saussure 1946, p. 367):

Such a condition is impossible, it has been said. Your monomaniac is merely a supposition; it is a convenient modern resource, whereby on the one hand the guilty may be saved from the severity of the law, and on the other, a citizen may be arbitrarily deprived of his liberty. Everyone who is aware of his own existence can resist his own impulses, especially when they are horrible and repugnant to the feelings. - - - Man can only lose his free will by the loss of reason - - -.

These words summarize well the reasoning of jurists on the concept of monomania.[43]

A similar debate was carried on in the English speaking world. Here, however, discussion of the monomania concept was never especially lively, the controversy focusing instead on a variant of the concept, namely "moral insanity". It was primarily through Prichard (cf. section 2.6.1, below), who embraced much of the theory of monomania, that French psychiatry became known in the English speaking world.[44]

In Germany this theory never gained a real foothold. Certainly Pinel's idea of mania without delirium was accepted by authors influenced by natural philosophy, such as Reil, Hoffbauer, Heinroth and Grohmann,[45] but as a psy-

[43] The following citation shows that there were ulterior motives for the animated exchange of words (Carlson & Dain 1962, p. 135): "John Van Buren, New York State Attorney General asserted in 1846 that to accept moral insanity as a legal entity would be to take the ultimate responsibility for judicial decision away from the laymen on the jury and confer it upon psychiatrists".

[44] Several earlier authors have counted Prichard among those critical of the theory of monomania (see e.g. Boismont 1853, p. 569). This probably is the result of a misconception or of too great weight being placed on a few isolated critical statements. He would not for example follow Heinroth and Esquirol in using intellect, feeling and will as a principle of division, since "propensities - - - are so nearly allied to passions and emotions, that they are generally referred to the same division of faculties - - -" (Prichard 1835, p. 10). Prichard concedes also that those who suffer from moral insanity, that is, disorder of the sphere of emotion and impulse, still exhibit a certain type of intellectual disturbance, since they think and act under the influence of strong emotion (ibid. p. 14). As shown above (cf. note 39) Esquirol was also of this opinion. However, Prichard's construction of the new disease category moral insanity builds largely on the possibility of a division of the mind into faculties which are relatively independent of each other.

[45] J.C.A. Grohmann (b. 1770), professor of philosophy, was a prolific writer on criminal law and forensic psychiatry. He is considered to be the first in Germany to have given a detailed description of ethical inferiority in terms of disease or organic defect. Jurists and those who make the laws must have a clear concept, he claims, of how human nature is composed, and should adjust laws and ordinances accordingly. He considers that there is something against nature in serious crime, which points to the mind beeing in a suspended state—or monstrous. Such an evil will is sick and cannot be judged according to ordinary rules of law.

Grohmann speaks of *moralische Insanie*, when the will or "the activity of the moral consciousness" is disturbed by disease (1818, p. 471). He further divides this derangement into *angeborener Stumpfsinn des Willens* (congenital feeble-mindedness of will), *angeborene Rohheit oder Brutalität* (congenital rawness or brutality) and *moralische Blödsinnigkeit oder Irrheit* (moral imbecility or insanity) (1819, p. 162). Thus he distinguishes between congenital moral derangement and moral derangement as an illness, a distinction which will become more general only during the latter part of the 19th century.

Grohmann builds entirely on traditional faculty psychology, which was of course a precondition

chiatry influenced by the natural sciences came to the fore in the 1840s, the theory of monomania was soon played out.

One of its earliest critics was Adolph Henke (see Herrlin 1904, pp. 128 ff.). However, the most significant of them was Wilhelm Griesinger (1817–68), the great name in German psychiatry during the middle 1800s. With his organically oriented textbook *Die Pathologie und Therapie der psychischen Krankheiten* (1845) he contributed much to the new trend in psychiatry which was so marked in Germany during this period.[46] The criticism directed by Griesinger and others at the theory of monomania was an aspect of the turning away from German "romantic" medicine, but was also a move away from symptom-fixed psychiatry.

2.6 The Early Moral Insanity Concept

2.6.1 Prichard: Moral Insanity

Even before Esquirol's *Des maladies mentales* had been published, Prichard had released his significant *A Treatise on Insanity* (1835) in England. As has been mentioned above, he had been much impressed by French psychiatry, above all by Pinel and Esquirol, and he dedicated his book to the latter, "the most distinguished writer of his age on the subject which I have endeavored to investigate" (p. iii). Despite this influence Prichard must be considered an independent, clear-sighted observer of psychopathologic phenomena.[47]

James Cowles Prichard (1786–1848) was a both learned and scientifically productive physician from Bristol, England. He had an inclination towards languages and had already as a child studied Greek, Latin, Italian, Spanish and French and later also German. This knowledge proved to be useful later in life when he acquainted himself with contemporary international psychiatric literature. Prichard's interests stretched far beyond the domain of the physician, and his magnum opus, *Researches into the Physical History of Man* treated anthropology and ethnography. An interest in psychiatric questions grew gradually. His first attempt in the subject, *A Treatise on Diseases of the Nervous*

for the theory of monomania and its equivalents; this is shown with all desired clarity in the following citation (1818, p. 491): "Each of the mental powers has its own average type in respect to activity, order and deviation. One may be healthy and another ill. - - The diseases of the mind are no less comprehensive and partial than the morbid affections of the body".*

[46] Regarding Griesinger's life and accomplishments see Thiele (1956). Griesinger's above named textbook was published in a number of revised editions. The second was translated into English in 1867 under the title *Mental Pathology and Terapeutics*. A facsimile of this edition was produced in 1965 with an introduction by the medical historian E.H. Ackerknecht.

[47] It is Leigh's opinion that Prichard has to a large extent been neglected by medical historians (1961, p. 148): "His concept of moral insanity, although based on faulty premises, exercised an important influence on psychiatric thought in England during the latter part of the nineteenth century. - - He played a decisive part in the introduction of French psychiatry to Great Britain - - -". For biographical data on Prichard see Leigh (1961).

System (1822) was an insignificant volume, showing affinities with the medical literature of the 18th century. Like Rush he prescribed massive bloodletting as a general cure for different forms of mental illness.

His *Diseases of the Nervous System* has interest for our present study primarily because in it Prichard adheres to the current intellectualistic interpretation of insanity. Regarding the occurrence of a mania without delirium he writes (cited in Leigh 1962, pp. 163 ff.):

> Notwithstanding the authority of general opinion and, what is of more consequence, the testimony of such a writer as M. Pinel, I cannot persuade myself of the accuracy of the reports on which the existence of this diesease rests. That a human being, in the possession of a clear understanding, having, therefore, a correct apprehension of social relations, of his own interest, and what he owes to others, should be suddenly transported by a paroxysm of rage, without any incitement in what seems to be universally and necessarily connected with the movements of anger, I mean an apprehension of real or unreal injury or offence, would be a phaenomenon quite at variance with the known laws of human nature. A passion or emotion taking place in the mind, implies an impression or idea adequate to call it forth. An emotion without a motive, is like an effect without a cause.

It is a very different author who confronts us in *Treatise on Insanity*, 1835. The somaticist, speaking for an etiological nosology has become a diagnostician satisfied with a symptom classification of a rather simple nature. Prichard admits that he had earlier doubted the existence of Pinel's *manie sans délire*, but reality had demonstrated to him that Pinel was right (ibid. p. 21). The discovery that the passions were not always a resultant effect of perceptions and cognitions, reflecting only their content, seems to have brought about a minor revolution in Prichard's thought. He returns to it again and again, writing for example (ibid. p. 112):

> The phenomena observed in this form of mental disorder (moral insanity) are so difficult to explain, that we might be tempted to doubt its existence as a primary affection, and to refer the appearances ultimately to the unperceived influence of delusive motions impressed upon the understanding.

According to the author, however, this is not so. The facts show the following to be the case (ibid.):

> The morbid phenomena which this disease displays in the moral constitution or feelings are independent of any corresponding affection of the understanding. - - - The sudden anger of a person labouring under moral insanity, and subject to paroxysms of rage, is not the result of fancied provocation which the individual has sustained from him who is the victim of object of his malice. It is not the revenge of supposed injury, but an immediate impulse arising spontaneously in the mind, which is diseased only in its moral constitution.

Prichard's new perspective is reflected in his classification of mental ailments. To a large extent he takes over the categories of Esquirol and Georget (cf. note 42, above). Thus he speaks of "monomania" or "partial insanity", of "mania" or "raving madness" and "dementia" or "incoherence". These three forms of derangement primarily affect "the understanding or rational powers" and he calls

them accordingly "intellectual insanity". However, in opposition to these he sets up disturbances which he relates only to the emotions and the will, placing them under the controversial heading "moral insanity" (ibid., pp. 6 f.).[48]

Moral insanity is then equivalent in principle to Esquirol's *monomanie affective* and *monomanie instinctive*, but in practice the conceptual parallelism is not that clear cut.[49] Prichard (ibid. p. 6) defines moral insanity thusly:

(A) madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination.

At another point he expresses himself in this way (ibid. p. 4):

There is - - - a form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone, in the state of the feelings, temper, or habits. In cases of this description the moral and active principles of the mind are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable, not of talking and reasoning upon any subject proposed to him, for this he will often do with great

[48] How did Prichard come upon the name moral insanity; did he coin it himself or borrow it from some other author? He himself gives no answer to this question, but does discuss to a certain extent the choice of designations for his disease category (Prichard 1835, p. 10): "If it were desirable to affix a single compound epithet to this class of mental disorders, the most appropriate would be Parapathia or, perhaps, Pathomania, in coincidence with the Monomania of M. Esquirol". But Prichard finally chooses "moral insanity". However, we can be fairly sure that he did not create the name himself. As early as 1782 the physician Thomas Arnold, with whom Prichard was apparently well acquainted, mentioned "moral insanity" on several occasions. What exactly Arnold means with the designation is difficult to determine, since he involves himself in extended discussions on the distinctions made by authors of antiquity between different types of mental disorder, but it seems obvious that he refers to that mild degree of "madness" of which all people are more or less guilty. He writes: "There is, indeed, some difficulty in determining the boundaries between what may not improperly be called *moral* and *medical* Insanity. Several of the ancient philosophers, and particularly SOCRATES and the STOICS considered every *foolish*, or *vitious* person as *insane*, or *morally mad*, by the *degree of disorder* - - -" (Arnold 1782, vol. 1, p. 89; cited in Carlsson & Dain 1962, p. 132. Corresponding passage in the German trans. of 1784 is found on p. 77).

Prichard was also acquainted with the German author Heinroth, who uses the expression *moralisches Irresein* in his volume of 1818. In Georg König's German translation of Rush's *Diseases of the Mind*, published in Leipzig under the title *Medizinische Untersuchungen und Beobachtungen über die Seelenkrankheiten* (1825), Rush's "moral derangement" is translated *moralische Störung* or *moralisches Irresein*. Similarly Grohmann (mentioned in note 45, above) wrote of *moralische Insanie*. Consequently there is a great likelihood that Prichard had encountered the combination "moral insanity" on various occasions in psychiatric literature.

[49] Prichard himself is not completely consistent in his use of the term moral insanity. In 1842, after having read Esquirol's comments on the concept, he altered his definition to make certain restrictions in the area it covered. Esquirol had written (1838, vol. 2, p. 63): "It may be that Dr. Prichard has not sufficiently distinguished moral insanity from another variety of insanity without derangement of intelligence and affections which Pinel called *manie sans délire*". Prichard agrees with this and writes (1842, p. 93): "This (*maine sans délire*), as M. Esquirol observes, is very distinct from that form of mental derangement which I have described under the term 'Moral Insanity'. It is best denoted by the expression instinctive madness or insane impulse". Consequently Prichard treats the latter group under a special chapter heading in his volume of 1842.

shrewdness and volubility, but of conducting himself with decency and propriety in the business of life. His wishes and inclinations, his attachments, his likings and dislikings have all undergone a morbid change, and this change appears to be the originating cause, or to lie at the foundation of any disturbance which the understanding itself may seem to have sustained, and even in some instances to form throughout the sole manifestation of the disease.[50]

Prichard is saying that with moral insanity it is often a question of disturbances or changes in the affective interaction with the environment that are so minor as to be unnoticed by the inattentive or untrained observer. Those who are closest, who know the affected person well, will notice that something has happened, that he is somehow different. He has for example become more moody, depressed, irritable or perhaps less sensitive to the welfare of those around him. He may be less strict morally, prideful, boasting, wasteful.

Prichard emphasizes that the disease may only amount to an accentuation of certain personality traits which have characterized the affected individual from childhood, so that it may be difficult to draw a line between behavior caused by disease and that exhibiting only eccentricity and depravity.[51] He writes for example (ibid. p. 23):

[50] It is the above quoted texts that are usually cited in present-day psychopathy literature, in the course of an introductory historical review. The citations undeniably contain phrases which are reminiscent of modern descriptions of psychopathy. For example Prichard writes of "a morbid perversion of natural feelings", and he claims that "the moral and active principles of the mind are strangely perverted and depraved". He also states that "the power of self-government is lost or greatly impaired", that there is nothing wrong with the ability of such a patient to enunciate his wishes, his problem being one "of conducting himself with decency and propriety in the business of life".

However, it is historically fallacious to attach such great significance to these texts only (cf. Henderson 1939, p. 11 f.). Prichard's concept must be seen against the background of contemporary medical and psychological theory. To what extent moral insanity is a predecessor of our present-day concept of psychopathy can only be determined through historical analysis, independent of how closely Prichard's descriptions of moral insanity coincide with present-day definitions of psychopathy. A similar view must be taken of the term moral. Thus, even if the above citation seems to connote immoral behavior, closer examination shows that Prichard is not using the term moral in the sense of "ethical", as for example Gerle (1955, p. 2) believes. Cf. section 2.3, above.

Physicians, or whoever else it might be, occupying themselves with psychiatric history as a kind of sideline, are often unable to see beyond the diagnostic categories of their own time. Their interpretation of older nosological concepts turn easily into an investigation of how correctly these concepts describe present-day "syndromes".

It is of course of interest to determine which forms of behavior have been labeled with this or that diagnostic term during a certain period, and one way of doing so is to describe these behaviors in terms of present-day psychiatric nosology. But it is certainly not necessary that this be done in such a fashion as to set up current concepts as ideal norms against which the more or less incorrect notions of older times are to be compared.

[51] In his *On the different Forms of Insanity in Relation to Jurisprudence* (1842), Prichard discusses the judicial consequences of the disease category moral insanity. He writes (p. 64): "The admission of such a state as really existing, is very important in a legal point of view; it brings with it many inconvenient results and it seems in some cases to confound insanity with eccentricity, or natural singularity of character". Prichard says further that he is aware that acceptance of moral insanity might lead to certain criminals escaping punishment, but "it is vain to shut our eyes against truth whatever inconvenient results may follow from admitting it" (p. 87).

On the other hand he believes that closer investigation would reveal that many eccentric in-

The discrimination—if the two things are essentially different—could only be made in particular instances by taking into account a variety of circumstances, such as the hereditary history of the individual and his consanguinity with persons decidedly insane, his former character and habits, and the inquiry whether he has undergone a change in these respects at some particular period of his life.

That a purely affective derangement might sometimes occur is thus established, according to Prichard, but is it therefore motivated to consider this type of disturbance as a separate illness? Prichard thinks so. He does not see the isolated affective disturbance as an "incubation of madness" (ibid. p. 17) but states rather that many cases of these diseases remain constant after the original change has occurred.

Prichard also considers possible causes of moral insanity. It can be a case of brain damage, epilepsy, fever, but also of an hereditary disposition or a previous insanity. From an etiological point of view it is then an obviously heterogeneous group Prichard attempts to collect in his new nosological unit. The symptomatology is also profuse: "In fact, the varieties of moral insanity are perhaps as numerous as the modifications of feeling or passion in the human mind" (ibid. p. 17). Hunter & Macalpine (1963, p. 837) comment on this:

It is clear that he cast his net far too wide and included a diversity of cases which would today fall into such categories as mental subnormality, schizophrenic states, manic-depressive psychosis, psychopathy, and the personality changes consequent upon organic disease of the central nervous system and degenerative conditions such as the 'senile insanity'.

The width of the concept is worth noting when one considers that a result of the continued debate would soon be its being limited to violent unrestrained and immoral behavior (cf. e.g. Kitching 1857). It may in fact be claimed that to a certain extent Prichard himself contributed to the narrowing of his concept, since his general description of the characteristics of moral insanity emphasizes morally deplorable behavior (cf. note 49, above).

Prichard's concept of moral insanity has been treated here in relative depth. In a presentation intended to relate the history of psychopathy concepts it should indeed take a prominent place, not because Prichard was, as so many authors in sweeping historical overviews claim, the first to encircle that behavior later to be regarded by many as psychopathic—this false account should definitely be corrected—but since it was he who brought the earlier French psychiatry to the English speaking world and also made original observations regarding emotional and behavioral disturbances. Through Prichard's descriptions the moral insanity concept was also at the center of interest in Great Britain and America.

dividuals do in fact suffer from moral insanity, though this would not mean that they must be committed to institutions. The deciding factor is whether or not they are able to take care of themselves to a satisfactory degree.

Prichard also refers to a number of noted historical personalities whom he believes may have suffered from moral insanity, such as Queen Christina of Sweden, Czar Paul of Russia, Fredrich II of Prussia and the visionary seer Swedenborg.

2.6.2 Debate in America on Moral Insanity

The moral insanity concept took a prominent role in discussion among American psychiatrists for many years. One who took part most actively in this debate was Isaac Ray (1807–81). During practically the entire period that the concept was the object of general interest in the USA, Ray acted as its defender. He was in fact one of those who introduced it in America.

Ray was only 31 years old when he published his significant *A Treatise on the Medical Jurisprudence of Insanity* (1838), the first systematic treatment in English of the problem of mental illness in relation to crime and punishment (cf. Overholser 1962, p. vii).[52] In this work he largely follows the French method of classifying mental disturbances, but introduces his own modifications. He divides mania into "intellectual mania" and "affective" or "moral mania". Both of these variants can be general or partial in nature. Thus Ray places the affective side of the mind at the same level as the intellectual, thereby adhering to the previously mentioned trend (cf. section 2.2, above) towards also considering disturbances to the non-intellectual mental functions as insanity.

Ray fully accepted the thesis that the brain was the organic substratum of the psyche: "It is an undoubted truth that - - - the intellectual and affective powers are connected with abnormal conditions of the brain" (Ray 1962, p. 58). He even claimed that pathological investigation confirmed this position. In addition to French researchers he cited Gall and Spurzheim on this, the foremost names in phrenology.[53] That the success of phrenological theory in America also influenced the acceptance of "moral insanity" is clear (cf. Dain & Carlson 1962, pp. 796 f. and Davies 1955, pp. 89 ff.).

[52] This work is quite remarkable, considering the conditions under which it was written. It is easy to agree with Pasamanick (1954/55), that it is an "inexplicable product from the pen of a rural general practitioner who probably did not see more than an occasional psychiatric case from year to year" (p. 164). The work was soon established as a classic of forensic psychiatry. It was published in many editions and proposed solutions to problems that have only been tried in our own time.

[53] Cf. Carlsson & Dain 1962, pp. 134, 796 f.; Davies 1955, esp. chap. 7: "Phrenology and Insanity"; as well as Bakan, 1966. For Gall, see Temkin (1947). Phrenology was brought to America primarily by Spurzheim, who traveled there in 1832. Shortly thereafter it swept like a prairie fire over the land. Phrenological societies were founded in many communities and the subject remained current for years. Gall had once been driven from Vienna for his supposedly materialistic teachings, which expressly tied the faculties of the mind to the activity of the brain. For all their religiosity, the Americans reacted differently. Certainly sermons were preached in churches against phrenology, which was seen as threatening the tenets of free will and the responsibility of man, but many believers did not see phrenological doctrines as a hinder to faith. The wellknown preacher Henry Ward Beecher, brother of Harriet Beecher Stowe, claimed for example that phrenology "underlaid his whole ministry and recommended as the best preparation for a Christian a practical knowledge of the human mind as it is given by phrenology" (Davies 1955, p. 163). Perhaps it is possible to see here a manifestation of the alleged American disaffection towards metaphysical reasoning and explanations. Phrenology was a firmly tangible and easily comprehensible theory, and it was marketed in traditional yankee style, with for example a number of "salesmen" who traveled the length and breadth of the land holding lectures and palpating craniums (cf. Bakan 1966, pp. 203 f.).

Ray early developed a great interest in phrenology and translated sections of Gall's massive work on the functioning of the brain into English.[54] Later (1879), when phrenology was a finished chapter even for him, he wrote (cited in Pasamanick 1954/55, p. 165):

Phrenology was to me in those days a revelation of new truth and especially of a philosophy that shed a marvelous light on the whole field of mental science.

Against the background of the phrenologic teaching of the localization of the mental faculties in the brain it is possible to understand how physicians like Ray who were influenced by phrenology were able to accept a purely affective mania more easily than others were.

According to this theory the emotional and conative faculties as well as the intellectual ones had well-defined sections of the brain as organic base, and these areas could be struck by isolated damages or be underdeveloped in relation to the other "centra". This would lead, as phrenologists looked at it, to a disturbance or underdevelopment of the equivalent mental faculties.[55]

Moral mania was for Ray only a new term for that group of emotional disturbances upon which Pinel had focused attention through his diagnostic category *manie sans délire*, but he considered that Pinel's cases were too one-sided (Ray 1962, pp. 127 f.):

The examples which he (Pinel) gives, being chiefly characterized by violent anger and unbounded fury, by no means furnish suitable illustrations of the affection now stiled moral insanity, though they do illustrate a particular form of that disorder. This defect, however, has been amply supplied by the researches of others, which have made us acquainted with a great number and variety of cases in which the affective faculties, either singly or collectively, were deranged, independently of any appreciable lesion of the intellect. The reality and importance of this distinction, which thus establishes two classes of mania, is now generally acknowledged by practical observers, among whom it is sufficient to mention Esquirol, Georget, Gall, Marc, Rush, Reil, Andrew Combe, Conolly and Pritchard.[56]

[54] This translation was only afterwards clarified by researchers. Official translator of the *Works of Franz J. Gall* published in Boston, 1835, in six volumes, was, according to the title page, Winslow Lewis, Jr. See also Pasamanick (1954/55), who handles this question.

[55] Ray's above "reminiscences" emphasize the impression that for many of the psychiatrists and psychologists of the day phrenology was a doctrine that could explain just about everything. Among Ray's colleagues was for example the well-known Amariah Brigham a warm adherent of phrenology.

Over a period of years Brigham wrote phrenologically-inspired articles for the *American Journal of Insanity* (see Davies 1955, p. 93). As early as in the second issue (1844) he explained: "The brain is not a single organ, but a congeries of organs, as maintained by the illustrious Gall and his celebrated successors Spurzheim and Combe. Thus each mental faculty has a special organ, and therefore certain faculties may be disordered by disease of the brain, while others are not affected; a fact every day observed in Lunatic Asylums, but which we know not how to explain if we believe the brain to be a single organ (*Am. J. Insan., 1*, 1844/45, p. 105). Davies summarizes (1955, p. 97): "What the alienists of 1830s and 1840s saw in phrenology was a body of experimental knowledge and a new approach to the problem of mental disease".

[56] Ray consistantly misspells Prichard's name (see Overholser 1962, p. 128, note 1). This may indicate that he did not consider him to be a significant authority. Ray does not seem to have ac-

Thus, like Prichard Ray emphasizes that moral mania or moral insanity should not be limited to a few syndromes as for example "the irresistible impulse", for in actuality this disease consists of many affective and behavioral disturbances.

Ray also based the partial form of moral mania to a high degree on phrenological ideas (ibid. p. 139):

> In this form of insanity the derangement is confined to one or a few of the affective faculties, the rest of the moral and intellectual constitution preserving its ordinary integrity. An exaltation of the vital forces in any part of the cerebral organism must necessarily be followed by increased activity and energy in the manifestations of the faculty connected with it.

As examples of such limited disorders Ray cites among others case descriptions by Benjamin Rush (irresistable inclination to steal in an otherwise morally firm person and inability to keep to the truth without any motive for lying; cf. Rush 1812, and section 2.4.1, above).

Ray did not wish to take a position in the question of whether moral mania was really a limited illness or should be considered as the initial phase of more general mental disorders, but "the fact that it may continue for an indefinite length of time and become the object of judicial investigation, gives it incalculable importance in a medico-legal point of view - - -" (ibid. p. 131). It was then, as we shall see further on in this section, the forensic aspects of moral insanity that should make the concept "*quaestio vexata*",[57] i.e., the most vexatious question faced in American psychiatry during a large part of the 19th century (cf. Bunker 1944, p. 197). The lively and occasionally acrimonious debate on "moral insanity" showed that for many of the involved parties this was not primarily a scientific problem but a question which touched their deepest values and in fact their philosophy of life (cf. note 43, above).

But even if Ray did meet resistance to the idea of an isolated affective mental disorder, a resistance which increased over the years, it must be considered an exaggeration when Zilboorg (1944, p. 561) speaks of Ray's "perseverence in almost single-handed proselytism of the theory of moral insanity". "Actually", write Dain & Carlsson (1962, p. 796), "the majority of the most original and important American psychiatrists before the Civil War - - - also accepted this concept".

tually had access to Prichard's *Treatise of Insanity* when he wrote his own work, since he refers to Prichard's article "Insanity" in the *Cyclopaedia of Practical Medicine*, as a source on moral insanity. This is understandable since Ray's volume was published three years after Prichard's, and at the time distribution was slow. Another interesting fact in the context is that Prichard also treats phrenology in his *Treatise*, but he maintains a critical and cautious stance.

[57] The expression derives from Pliny Earle (1809–92) a prominent psychiatric writer and superintendent, one of the famous thirteen who together with Ray founded *The Association of Medical Superintendents of American Institutions for the Insane* in 1844. This was the first medical society in the U.S., the predecessor of the present *American Psychiatric Association*. According to Bunker (1944, p. 197) the expression *quaestio vexata* is found in an article of Earle in the *Am. J. Insan., 24,* 1867/68, p. 275.

One of these physicians was Amariah Brigham (1798–1849), editor and founder of the *American Journal of Insanity*, the first psychiatric periodical in the English-speaking world and forerunner of the present *American Journal of Psychiatry*. Like Ray this man believed in the scientific nature of phrenology but obviously also had other reasons for defending the idea of moral insanity. He had a keen eye for the depth dimension in man, an insight into the fundamental importance of the emotions for personality development and human behavior, which he could not unite with the traditional intellectualistic view of mental illness (Brigham 1844/45, pp. 107 f.):

> We do not wish to undervalue the intellect - - - but we wish that all might realise the superiority of our moral nature over intellect itself. The intellectual faculties are but a part of our mental powers, and contribute but little in fact towards forming what we call the *character* of an individual. - - - The stimulus or urgency of the impulse of our moral nature, of benevolence, love, avarice, etc., impel man to action—to gratify these the human race have forever toiled.

But different voices were soon to be heard in the *American Journal of Insanity*. From 1855 until the time of his death John P. Gray (1825–86) was editor of the journal and in its pages polemicised inexhaustibly against those with differing view-points.[58] This trend-setting physician belonged to a later generation of psychiatrists with an extreme somatic orientation, which was not, however, phrenologically based. Gray was hardly satisfied to consider mental illness to be expression of a pathologic brain, but even denied that any mental disturbances at all could have direct psychic causes. It seemed impossible to him that, for example, a deep sorrow could become a pathological melancholy. He would only speak of "moral causes", that is psychological causes, to the extent to which such factors prevented an individual from getting enough rest, sleep, food or the like. Organic lesions to the nervous system and brain might result from these, which could in turn lead to mental disturbance.

Insanity was for Gray "a disease of the brain, in which there is an association of mental disturbance" (Gray 1881/82, p. 393). He considered this position to be empirically based. With a wide-ranging experience of the dissection room and the reading of autopsy reports as background he thus claimed (ibid. p. 435):

> I have never found a case of insanity, in the institution or anywhere else, that I have examined that I did not find a diseased condition of the body in some of its organs reflecting itself upon the brain so as to produce disturbance in the nutrition of that organ or actual disease of the structure of the brain itself or the membranes.

During the last three or four decades of the 19th century most of Gray's colleagues had a similar view of psychic ailments and largely relied in that respect

[58] In his well-known work on the development of American mental health services, *The Mentally Ill in America* (1949), Deutch treats the above mentioned debate and those who participated in it. He characterizes Gray as "the most vociferous psychiatric polemicist of them all" (1944, p. 346).

on European psychiatry which at the time had a long line of prominent spokesmen for this anatomical-pathological approach.[59]

Gray's position meant that he also rejected "moral treatment", the humanistically-inspired method of treatment which American psychiatrists had adopted from France and England, and which was used with great enthusiasm in many areas of America into the 1860s. This method of treatment was coupled with "the cult of curability" (Deutsch 1949), that is, the exaggerated belief in the possibility of curing mental illness which directed American psychiatry especially in the 1840s. This conviction also led to certain institutions submitting reports which spoke of nearly 100 per cent of cases cured. When reality eventually revised these over-optimistic figures, which were partially built on inadequate knowledge of statistics, the belief in moral treatment also tended to disappear.[60]

In America there occurred a tie between the concepts "moral causes" and "moral insanity". This way one of the reasons that many in the new generation of psychiatrists dissociated themselves from "moral insanity", for the concept implied "a non-somatic approach (which) smacked of medical heresy" (Dain & Carlson 1962, p. 797). As we have seen above the idea of partial affective or conative illness has also been linked to phrenological notions of the anatomy and functions of the brain. The abandonment of these ideas also contributed to the reduced status of the theory of moral insanity.

But Gray had additional reasons for disapproving of the moral insanity concept. He might have been able like many of the organically-oriented European psychiatrists (e.g. Maudsley, Lombroso, Krafft-Ebing and Magnan, to take representatives of different nations), to accept a relatively isolated disturbance of emotions and impulses on an organic base, but for Gray this step would also have meant an expansion of the concept of insanity which could not be accepted for reasons of religion, legal philosophy and social morality.

For Gray the concept of illness was firmly bound to somatic lesion or dysfunction, and in a case of mental disorder where such a lesion could not be assumed to exist or be determined through a post mortem it could then not be considered "in-

[59] During the last half of the 19th century a number of American psychiatrists were in fact more orthodox somatics than were their European authorities (cf. Bunker 1944, p. 207). In a lecture given in 1872 Gray stated that he himself was convinced of "what Maudsley is 'tempted sometimes to think' that insanity occurs only as the result of physical causation—that a necessary antecedent to madness is a disordered physical state of the brain—that it never occurs in a person of sound brain" (cited in Bunker 1944, p. 210).

Also Brigham was basically a somatic. He wrote: "It is true that moral and mental causes may produce insanity, but they produce it by first occasioning either functional or organic disease of the brain" (cited in Bunker 1944, p. 210). This attitude is consistent with Brigham's phrenological approach. However, Brigham's and Gray's seemingly similar basic opinions led, as described above, to quite different conclusions.

[60] Cf. Ozarin 1954/55; Dain & Carlsson 1962, p. 796; Bockoven 1963; Savino & Mills 1967. The last-named authors emphasize that "moral treatment" survived in the western areas of the U.S. for at least two more decades, partly because for years after the middle of the century new institutions were built, which not yet had to deal with a large number of chronic cases.

sanity" but only "eccentricity", "depravity", or "vice". Accordingly he claims (Gray 1881/82, p. 425):

There is a profound distinction (recognized between actual disease of the mind and mere demoralization). In the first place, insanity is in all instances the offspring of disease, and when a person who is insane manifests evidences of depravity, so to speak, in his acts or speech, that is a mere offspring of disease, whereas the other is the offspring of education in vicious lines of thought and conduct and from the indulgence of passions. A man may become profoundly depraved and degraded by mental habit and yet not be insane.

In 1858 Gray wrote an article on moral insanity for the *American Journal of Insanity* which illuminates his position, which in comparison with European approaches is a somewhat singular combination of strict somaticism, fundamentalist Christian belief and conviction of the freedom of the will.[61] Several selections follow (Gray 1857/58, pp. 311 f.):

The first recorded case of homicide, and it was a fratricide too, was committed by the first-born of mankind against the second-born. - - - What possible motive that a sane man would acknowledge, could Cain have for slaying his younger brother? - - - He slew him from mere jealousy or envy, as appears, because of Abel's greater favor with God. Seemingly, a right-minded man, in the full possession of his senses, could have committed no such double crime upon so little provocation, and for no possible advantage; and, therefore, it would be fair to infer, that Cain had dwelt upon what he deemed a grievance until his senses were unsettled, and he was no longer the responsible master of his actions;—in short, that he was morally or impulsively insane. - - - It is fortunate that this first case of homicide had a more competent tribunal to establish a precedent than human laws provide.

Further along in the article Gray writes (p. 314):

Violence against the person and against property is now so prevalent, that we should be more than commonly cautious of recognizing any doubtful form of insanity that will

[61] During the latter part of the 19th century most psychologists and psychiatrists of any rank were positivists, hence determinists. Talk of free will was for them a passing stage, since man was obviously a higher animal and thus governed by the laws of nature. However, for many religionists it was impossible to reconcile this point of view with the conviction that man has responsibility before God for his acts.

It is interesting to compare the believer Gray and his way of dealing with this dilemma and the attempt at a solution made by another Christian physician, Heinroth (see note 7, above). The latter was a radical and consistent advocate of the doctrine of freedom of the will, which he saw as the key to understanding the nature of psychic illness. Heinroth draws a distinct line between body and mind (*Seele*). The body is exclusively natural matter and governed by the laws of nature. The psyche of man on the other hand is above those laws and is thus not bound by the impulses and instincts of the body. In accordance with this, somatic diseases are one thing, diseases of the mind another. When the mind has become sick, it is because its freedom has been limited, but this limitation of freedom of the will can only take place through one's own negligence in not having lived after God's law. One has then misused freedom which leads to its abrogation (see Herrlin 1904, p. 107).

Gray, however, attempts to preserve freedom of will and the responsibility of man through claiming that there only exists diseased mental activity caused by organic lesions or dysfunctions of the brain and nervous system. Such somatically based disturbances can, however, limit the freedom of the individual to act in accordance with his will. Thus he is morally and legally unaccountable.

shield it; and it is safe to assume that unless we know upon competent proof, that some form or other of physical disease has produced 'a state of insanity,' it is not just to society, to claim for any homicide, or other violence, the protection of such a defence.

In 1861 Ray published a defence of the moral insanity concept in the above-named periodical. There he claims that his duty as a scientist is to interpret the facts of nature—regardless of the consequences. For him it was clear that the emotions could be struck by disease without this meaning that the ability of the intellect was also reduced. His conviction would not permit him to compromise even if "moral insanity" as an explanation of certain criminal actions was according to some, dangerous for the common conception of justice.

The American Journal of Insanity published a considerable number of legal cases in which physicians were called on for medico-legal judgement. In 1865 for example there was a discussion of a certain Townley who murdered his fiancée and eventually committed suicide. The man was considered by medical experts to have suffered from moral insanity. From a very critical article on the case in *The Saturday Review* the following was taken with approval (Gray 1865/66, pp. 133 f.):

> It is a mere question of words, and saves the trouble of thought. If experts choose to say that all very great criminals and scoundrels of extravagant wickedness are ipso facto morally insane - - - we have no particular objection to their saying so. All that comes out of it is to deprive the word 'insanity' of any real meaning. When, however, we come to practical conclusion, we are at issue with the ingenious practicioners who hold this doctrine of moral insanity. We would hang the victim of moral insanity; they would not. - - - Insanity, as hitherto used by articulately speaking men, is inconsistent with responsibility; but in the gabble of medical science, irresponsibility is proved by the mere fact of extraordinary immorality.[62]

A similarly much-debated case in which the diagnosis of moral insanity was suggested was that of Charles J. Guiteau who murdered President Garfield in 1881. The exchange of words between the opposing camps at this trial was exceptionally vehement and unscientific.[63] MacDonald stated for example (*Am. J. Insan., 38*, 1881/82, p. 372):

[62] What has been touched on here has been and is still a key problem in forensic psychiatry. Galdston (1962) claims in a discussion that even though "moral insanity" represents a nosological step forward, and has led to such concepts as psychopathic personality and character neurosis, psychiatrists have not remained satisfied with this. Instead they have "developed its (the concept of moral insanity's) implications in terms of 'responsibility'. This, so to say, catapulted the psychiatrist into the legal arena *and* 'that's where the trouble began'" (p. 800). This, according to Galdston, was something psychiatrists should not have done, "for the psychiatrist henceforth was not simply an *amicus curae* but became the protagonist of a definitive point of view intrusive on the prerogatives of judge and jury" (ibid.).

[63] George M. Beard, originator of the term neurasthenia (see chap. 3, note 8, below) was one of the defenders of the concept moral insanity at the Guiteau trial. Another prominent opponent of Gray and those who were in agreement with him was the neurologist William A. Hammond (1828–1900). Both of these men were published in the neurology-oriented *Journal of Nervous and Mental Disease*, which followed a more positivist line than that of the *American Journal of In-*

I do not believe in it (moral insanity) myself. I have never seen a case. Moral insanity is another name, and has been from the time of its invention, for wickedness and depravity. Its first use, I believe, was at the time of French Revolution, and it was meant to excuse the slaughter that took place then.

The debate continued in this tone for many years, and for nearly a half century no significantly new views were forthcoming. During the 1880s discussion ebbed out, but not necessarily because the question of moral insanity had been resolved. Zilboorg writes (1944, p. 563):

When the subject is dropped, the impression is gained that it was all but an episode of no great consequence and deserves to be respectfully forgotten, or if recalled, recalled as an ephemeral curiosity of an unenlightened age. That this is not always so is overlooked. It was not so as far as the issue of moral insanity is concerned. That it seems to have been forgotten, is true, but its importance is still to be appreciated by our own generation of psychiatrists, whose attitude toward crime has changed so radically in the last twenty-five years.

2.6.3 The Moral Insanity Concept in France and Germany up to the 1860s

In France Prichard's concept of moral insanity was regarded as a variant of Esquirol's monomanias. Esquirol himself compared Prichard's diagnostic category with his own *monomanie affective*, that is, he considered the qualifier "moral" in "moral insanity" to be synonymous with "affective". But also for many in France *folie morale* and its synonyms[64] came to be only a designation for a certain group of difficult patients: egoistic, querulous, unreasonable, but at the same time flattering and false. Of course those "monomaniacs" who committed criminal deeds and whose position in law was to generate so intensive debate were also placed in this group (cf. Saussure 1946 and section 2.5, above).

Regarding monomania with disorder of the emotions and will only, discussion centered primarily on the following question (Falret Jr. 1866/67, p. 409):

May the moral powers be separately affected by disease, without concomitant disorder of the intellectual faculties, or on the contrary, does there exist in all cases without exception, and notwithstanding the greater manifestation of disease in one of these departments, a lesion, at the same time, in both the grand divisions of mind?

sanity, dominated by Gray. Regarding their contributions to the above debate see Beard (1882) and Hammond (1882).

Against the background of what has been said above regarding the later, strictly somatic generation of psychiatrists it may seem inconsistent to have neurologists defending a diagnosis of moral insanity. But the concept Beard and Hammond had in mind is hardly that of Brigham and Ray; it is rather "moral insanity" as the illness was defined by the French and German theoreticians of degeneration (see chap. 4, below).

[64] The major conceptual confusion in this area is of course reflected in many diagnostic terms. Thus Falret Jr. (1866/67) speaks of "the several varieties of insanity brought together provisionally under the vague terms reasoning insanity, moral insanity, mania without delirium, or insanity of the acts" (pp. 407 f.). Equivalent French expressions are *folie raisonnante, folie morale, manie sans délire, folie des actes.*

During these years an increasing number of French psychiatrists were convinced that the latter relationship was the correct one. Critics such as Falret *père et fils*, Foville, de Boismont and the later so famed Morel emphasized that the psychology upon which the theory of monomania was based—and therefore also the concept of moral insanity—was obsolete. Falret Jr. writes (1866/67, p. 410):

> The fundamental error in all the writings of medical alienists of every country, since the beginning of the century is, that they have transferred into mental medicine, without change, the classification of the faculties laid down by professed psychologists for the study of the normal mind.

This refers to a psychology that, in accordance with phrenology, considered the psyche to be a conglomerate of faculties which were able to function relatively independent of each other. According to the critics named above, experience spoke not for such a theory, rather for "unity of mind and for solidarity of its faculties" (Boismont 1853, p. 591).*

As has been pointed out earlier (cf. section 2.5, above) the doctrine of monomania was never as prevalent in Germany as in France. In connection with a general move away from medicine influenced by nature philosophy, there was also a tendency to abandon faculty psychology and its psychiatric offshoots.[65]

Indeed, Griesinger went so far as to casually refer to Pinel's *manie sans délire* as "a mishap for science" (see Griesinger 1845, p. 236). An isolated affective disorder without any disturbance of the mind as a whole was something he had great difficulty in supposing. Those actual anomalies which the French and Prichard attempted to encompass with their respective concepts were not considered by Griesinger to be circumscribed diseases but as non-developed forms of mania.

2.7 Summary

The 18th century view of mental disorders was above all rationalistic. Accordingly, the key word in definitions of "madness" from this time is "delirium", a term indicating a disturbance of the intellect in the widest meaning. But a cultural development towards an increasing acknowledgement of the emotions went on during the latter part of the 18th and beginning of the 19th century. The discovery which was then made by certain physicians that many mental illnesses do not fit

[65] In his historical review of the moral insanity concept Müller (1899, p. 330) claims that the Germans, at a point much earlier than the French or the English, rejected the psychology which lay behind the concepts of monomania and moral insanity. According to Knop (*Allg. Z. Psychiat., 31*, 1875, pp. 697 ff.) this can be explained in part by the influence of the psychologist Herbart, who emphasized the unity of the mind. Leibbrand & Wettley (1961, p. 515) indirectly confirm this opinion by pointing out how closely Griesinger's psychology follows that of Herbart. That Griesinger's psychological views had in turn a significant influence on German psychopathology is something that can certainly be assumed, considering his central position at the time.

intellectualist definitions, and that in many of these diseases it is a case of the emotions being disordered, rather than the understanding, was in harmony with romantic currents of thought. Obviously a precondition of this discovery is that empirical study of the phenomenon was being undertaken.

It is in the light of this new cultural and scientific spirit that Rush describes "derangement in the will", "derangement of the passions" and "moral derangement", while Pinel speaks of *manie sans délire*, Esquirol of *monomanie affective* and *instinctive*, Prichard of "moral insanity". These diagnostic terms amount to an admittance that even the non-cognitive side of the personality can fall victim to disorders, indeed, at times seem to be the only function disturbed.

But in the period under consideration another intellectual tradition can also be traced, one which maintains the distinction between total and partial insanity, the former linked to the term mania, the latter to melancholy. This tradition is connected with the rationalistic interpretation of madness: mania is characterised by an almost total loss of reason, while melancholy is only a disturbance of certain ideas or conceptions. Otherwise the melancholist thinks and acts like other people.

In his nosological system, which had been influenced by the then increasingly common division of the mind into understanding, will, and emotions, Esquirol now also integrated the non-intellectual psychic disturbances under the conceptual heading "partial insanity" or "monomania". We then see, in addition to the old type of monomania—the intellectual, in which the disorder was manifested in an *idée fixe*—also affective and instinctive monomanias; it is these last that have interest for us here.

Although Prichard distinguishes between monomania, which for him maintains the connotation of partial intellectual disturbance, and moral insanity as an affective and conative disorder, his concept is for the most part identical with the affective and volitional monomanias of the French.

What, then, does this vague concept of an isolated non-intellectual insanity have to do with the phenomena today named as psychopathy? Through the discovery that there were grave emotional disturbances that were not brought about by traditionally expected disorders in the understanding, the distinct but false line separating sense from "madness" was erased. But at the same time a diffuse and widespread boundary area between mental health and disease was discovered, an area which psychopathologists have attempted to chart since that time. From that area different "syndromes" have later been differentiated such as neuroses, psychopathies and incubatory stages of psychoses.

But we have also seen that within the vague concept of affective-conative disorder a more limited concept began to crystallize. This was "moral derangement" in Rush's sense, that is, a concept referring to asocial, ethically inferior behavior which does not, however, stem from "normal" evil, but is a result of illness.

Because of the forensic, moral and religious significance of these supposedly involuntary, sick actions, interest was focused on them from many directions and the concept of moral insanity, which was broad by definition, encompassing more

than just these kinds of behavior, was rapidly made more narrow. As early as the 1840s and 50s, then, Prichard's diagnostic concept had for certain doctors and for most initiated laymen, above all jurists, a connotation similar to that of Rush's moral derangement. A confusion about the meaning of the term moral also contributed to this development.

It should, however, be observed that in France a similar limitation of significance can be traced with such terms as for example *manie sans délire, folie raisonnante* and *monomanie affective*. There the synonym *folie morale* does not seem to be the most commonly occurring until Morel's work became generally known during the 1860s. In France, then, the attribute *morale* cannot have played the same role in the presently considered developments as it had in the English-speaking nations.

3 Heredity and Degeneration within Psychopathology

3.1 The New Medicine and Its Influence on Psychopathology[1]

The time immediately after the revolution in France was as we have seen important for psychiatry but also for medicine generally. It was during the first decades of the new century that the famous clinical Paris school developed, generally considered to be the primary source of modern medicine (cf. e.g. Ackerknecht 1967).

Characteristic for the new researchers—G.L. Bayle, Laënnec, Louis, Andral and others—was their clinical-pathological method: symptom pictures were continually compared with pathological discoveries obtained at the regularly utilized autopsy table. The large Paris hospitals, "refuseheaps" of the big city and a growing industrialism, provided researchers with renewed supplies of human material. New diagnostic methods were discovered and taken into use, as for example percussion, developed by Napoleon's personal physician Corvisart (1755–1821), and examination with the stethoscope, an instrument constructed by Laënnec (1781–1826).

Also statistics now made their début in medical research, termed the "numerical method". With the aid of statistics, Louis (1787–1872) was able to establish that the practice of bloodletting, employed for thousands of years, was in fact therapeutically worthless.

But there was also a danger in the new scientific spirit and in the facts brought to light, for though the flaws in the old methods of treatment were shown, there was very little to use in their stead. A therapeutic pessimism began to spread among doctors, and their helplessness was reflected in sinking public faith in the profession. The market for amateur healers and charlatanism was on the other hand a lively one.

Another negative effect of the interest in research was that the attention of physicians was increasingly occupied by diseased organs and the course of illnesses. The sick *person* was in that way considered only secondarily, and the understanding of the human being as a psycho-physiological entity was diminished. These tendencies show themselves most clearly in the Viennese descendants of the Paris School, above all perhaps in the clinician Skoda (1805–81) and the

[1] In the composition of section 3.1 I have drawn primarily on Major (1964); Shryock (1936); Zilboorg & Henry (1941); Sigerist (1944, 1947).

pathologist Rokitansky (1804–78), those men who made the Vienna of the 1840s an international center for research in pathology: "Never had there been a study of the fundamental branches of clinical medicine and pathology, nor so complete a disregard of therapy and the interests of the patients" (Shryock 1936, p. 183).

The first decades of the 19th century saw in Germany a flourishing of nature philosophy-inspired medicine. However, during the 1820s there was a change in orientation. Young men arrived from Paris and later Vienna, filled with enthusiasm for science. Soon intensive physiological and medical research was being carried out at the many small but well-organized German universities. A central figure in this scientific revolution was Johannes Müller (1801–58), professor in Bonn and Berlin, among other places. A long line of the outstanding researchers of the next generation were his students, among them Schwann, Virchow, Helmholtz, Du Bois-Reymond, Brücke and Ludwig.

Typical of the times was the social club (*Kameradenverein*) founded by the latter four in the middle of the 1840s. The devotion shown by these young men in their demolition of vitalism and preaching of physical reductionism was—as Jones (1953, p. 47) implies—not only an enthusiasm for a program of research; it was based in a *Weltanschaung*, a philosophical view of the universe. To be noted is for example what Du Bois-Reymond wrote in 1842 (cited in Jones 1953, p. 45):

> Brücke and I pledged a solemn oath to put into effect this truth: No other forces than the common physical and chemical ones are active within the organism - - -.

In summary it can be stated that in the first half of the 19th century medical progress was seen in the fields of physical diagnosis, with the clarification of a number of diseases as well as discoveries in the area of basic medical science. However, as indicated above, therapeutic progress did not keep step. It was not until the end of the century that the sick truly began to benefit from the results of medical science.

Of course psychiatrists were strongly influenced by successes in the natural sciences, especially in medicine. The previously tentative attitude towards the question of what constituted mental illness finally became more decided: it was quite simply disease of the brain. Seen from the viewpoint of the natural science and materialism of the time, it could be nothing else, even if decisive proof of this thesis was still lacking. Broussais' well-known words became a credo for many psychiatrists and neurologists: "If the cadavers do appear to us occasionally mute, it is because we do not know how to question them" (Zilboorg & Henry 1941, p. 439).

Consequently it was felt that the job of researchers was to ask nature the right questions, an attitude which dictated the choice of research methodology. Many were convinced that the clinical-pathological method would also give results in the question of psychic ailments. It was hoped that local lesions would be discovered in the brain, which would make it possible to definitely distinguish the various symptom pictures from each other.

Neurology made great strides along this path. Duchenne (1806–75), one of the pioneers in this discipline, was early able to describe a number of organic nerve diseases, in 1855 for example localizing polio myelitic paralysis to injuries of the anterior horns of the spinal cord. These early neurological steps forward would be followed by many others in the remaining years of the 1800s.

Progress in neurology also contributed to directing research in psychopathology towards anatomical and physiological examinations. The solution to the mystery of mental diseases was no longer considered to lie in penetrating psychological studies but rather in the dissection room and the laboratory. It was to this sanctuary that the new "scientific" psychiatrist withdrew, as soon as he was given the opportunity: "The mental life which he saw on the wards was to him 'brainlife' (*Hirnleben*) as Leiderdorf expressed it" (Zilboorg & Henry 1941, pp. 439 f.).

An extreme example of this type of psychiatrist was Theodor Meynert (1833–92), Freud's teacher in psychiatry. In 1884 in his well-known textbook *Psychiatrie, Klinik der Erkrankungen des Vorderhirns* (Psychiatry, Clinical Treatise of the Diseases of the Fore Brain; note the title!) he formulated theories on the anatomical basis of mental disturbances which in regard to speculative assumption, were not long after those of the 18th century system constructors.[2] "This trend was evident throughout the century", write Zilboorg & Henry (1941, p. 441), "and was not confined to the German-speaking world. It was deservedly called by Gruhle the school of 'brain mythology'."

As far as psychiatry was concerned, success was longer in coming. Considering this discipline, historians have as in the case of somatic medicine, spoken of a growing therapeutic nihilism at the middle of the century, based among other things on the poor results yielded by many years of anatomical-pathological research. It was not even possible to emulate somatic medicine in delimiting individual illnesses, much less cure them. The so-called moral treatment which

[2] Riese (1967) claims that the anatomical-pathological interpretation of mental illness peaked with Meynert's textbook. He writes (pp. 114 f.): "The entire first part, comprising no less than 285 pages, was devoted to the anatomy, physiology and chemistry of the brain. The author's preface is representative of the whole approach - -: The reader will find no other definition of 'Psychiatry' in this book but the one given in the title page: Clinical Treatise on Diseases of the Fore Brain' ".

Riese continues (p. 115): "Today we can hardly imagine the tremendous impact his work had on his contemporaries". One of Meynert's students, the later so famed Karl Wernicke (1848–1905), considered for example that the book was "equal only to the ever youthful and imperishable creations of the most eminent genius of all times" (ibid.).

Still, an insightful skepticism regarding the anatomical-pathological explanation model was not lacking. The English psychiatrist Daniel Hack Tuke (see section 4.4, below) was one of those who raised a skeptical voice. During the 1850s he visited the Dutchman Schroeder van der Kolk, a researcher full of enthusiasm for the above mentioned approach. Tuke writes (1882, pp. 477 f.): "This enthusiasm I cannot but suspect insensibly coloured what he saw in the brains and cords of the insane, or he would hardly have said, as he did say, that he had never failed during a quarter of a century to find a satisfactory explanation after death of the morbid mental phenomena during life".

earlier psychiatrists had believed in was not accommodated to the new perspective on mental illnesses and was therefore successively abandoned. Ackerknecht (1970, p. 226) has demonstrated that this pessimism was justified. The large hospitals were, after many years of activity, over-filled with chronic patients and cases of general paresis.

3.2 Development of the Theory of Degeneration

3.2.1 Background

It is an extremely old idea that disease may be hereditary. In the Hippocratic writings for example it is stated: "For of the seed, which is collected from all parts of the body, sound parts will come from sound and diseased parts from diseased" (cited in Vestberg 1948, p. 24).* This was also applicable to mental disturbances, to the extent that they were considered to be diseases. It was obvious to Pinel that heredity played a part in the origin of mental illnesses, and this view was shared by Esquirol and Prichard. However, heredity was for these men only one vague causal factor among many and attracted no special interest.

Towards the middle of the century an increasing amount of attention was paid to the question of heredity as an origin of mental illnesses. A contributing factor may well have been the feeling of hopelessness which, as indicated in the preceding section, had begun to spread among an increasing number of psychiatrists. It may be that an explanation was required for the lack of success, an explanation that might not give hope of rapid therapeutic progress, yet still could serve as a kind of absolution for the many failures (cf. Ackerknecht 1957, p. 50).

A work which proved to be of great significance for psychiatric and neurological theory-construction was Prosper Lucas' *Traité philosophique et physiologique de l'hérédité naturelle*, published in two volumes in 1847–50. This author strongly emphasized the role of heredity in the origin of nervous and mental disorders. Heredity was for him basically a question of the transfer of something similar from one generation to another (Lucas 1850, vol. 2, p. 534). However, this rule is not absolute. A certain illness can, as is well known, vary to a high degree even in the individual, so that for Lucas it followed that an inherited disease can change its form, taking a different shape in offspring than in parents. This would be particularly true for ailments of the nervous system. He also thought that a crossing of the morbid germs of the mother and the father could give rise to something quite new (ibid. p. 534). Thus in spite of the fact that Lucas began with the Hippocratic rule of inheritance which states that like give birth to like, his theories encouraged the notion of a polymorphic inheritance,[3] that is, a transfer

[3] From a shifting terminology I have chosen to use the expression polymorphic inheritance or heredity. Occasionally one sees the term hereditary polymorphism; Vestberg (1948, pp. 22 ff.) speaks alternatively of transformational heredity (*förvandlande ärftlighet*) and the theory of transformation (*transformationsläran*). Early French theoreticians in the area used the expression *hérédité du dissembable*.

from one generation to another of predisposition to illness which might give rise to widely disparate symptoms in the respective carriers.

Vestberg (1948, p. 25) finds evidence of this way of thinking in certain writers as early as the 1600s. However, they are given a considerably more educated expression with the noted French physician Portal (1742–1832) who wrote at the beginning of the 19th century (cited in Vestberg, ibid.):

> Hereditary diseases often replace or follow each other. In the same family one has seen one child epileptic and another manic, or found that the same person suffers first from one illness and then of another and finally succumbs to apoplexy. These changes or permutations of diseases of the brain are less surprising when one knows that anatomists have found the same changes in this organ in individuals who have died of apoplexy, epilepsy, mania or dementia (*stupidité*).*

Opinions similar to those expressed above were subsequently given an increasingly prominent position within psychiatry and neurology. Moreau de Tours (1804–84), for example, emphasized in his work *Psychologie morbide* that all the diseases of the nervous system were closely related. In fact they could be seen "as children from the same family, as branches of the same trunk" (cited in Genil-Perrin 1913, p. 37).* However, it is first with Morel that we find a more carefully worked-out theory of polymorphic heredity in the area of nervous and mental diseases.

3.2.2 Morel and His Theory

Bénédict Auguste Morel (1809–73) was a typical exponent of the development undergone by psychiatry in the years around the middle of the last century (cf. Zilboorg & Henry 1941, p. 401). As a student of the older Falret, he begins by emphasizing the need for psychological study of the mentally ill. However, new impulses caused him to develop in another direction. He began to study the process of reproduction and the question of heredity, being strongly impressed by Lucas, among others (see Genil-Perrin 1913, p. 34). Heredity became for him the dominant etiological factor in mental diseases. He was also interested in the physical and psychic characteristics of alien races. Under these influences he developed his own theory of mental degeneration.

"Degeneration" has, as Wettley (1959, p. 193) demonstrates, included widely disparate notions.[4] For Morel the term came to signify a singular mixture of

[4] Neither the idea of polymorphic heredity nor that of gradual deterioration was a product of the 1800s; Talbot (1898, p. 5) reviews an interesting example of the idea of deterioration taken from the 16th century. Vesalius (1514–64) had claimed that Galen's anatomy could not be based on actual studies of the human body, since so much in his descriptions was obviously false. For example, Galen describes a jaw bone (an intermaxillary bone) that Vesalius was not able to find in human beings. Such arrogance in the face of the greatest medical authority of the time could not be tolerated by Sylvius (1478–1555), who came to Galen's defence: "It is luxury, it is sensuality which has gradually deprived man of this bone".

According to Wettley (1959, p. 193) the concept of degeneration had a very vague and shifting

religious conceptions and anthropological hypotheses, as well as theories of disease and heredity.[5]

In his thorough monograph on the subject Genil-Perrin (1913) attempts to distinguish the "ingredients" in Morel's teachings. He finds that the somatic view of mental illness was an important precondition, through which such ailments were placed under the same physiological rules as ordinary physical diseases and could be approached with the methods of natural science. Additionally, one of Morel's great goals in life was to establish psychiatry as a respected member of the great medical family (see Morel 1857, p. xii). From the theories of his contemporaries Morel also took over the belief that hereditary diseases could express themselves in disparate symptoms (polymorphic heredity).

What can be added in the light of present-day genetics is that Morel's concept of heredity included the belief that acquired characteristics and diseases can be passed on to following generations. These notions comprised a significant part of his theory of degeneration and contributed to its lack of clarity.

Just as the igniting spark causes oxygen and hydrogen to unite as water, states Genil-Perrin, so in the area of thought is a spark needed which will cause various ideas to combine in a synthesis. In the case of Morel he finds this spark in his faith in the biblical account of creation. Morel rejected any ideas of evolution. To his mind the first three chapters of Genesis were clear on the point: the species were created in an unalterable form (see Morel 1857, p. 2).

All variation which de facto exists must be seen as a deviation from the original type (*type primitif*). Through Original Sin—which can for that matter be seen as an early example of the belief that certain acquired characteristics are inherited—mankind degenerated, according to Morel, and became thus receptive of all sorts of negative influences, physical as well as psychic. However, in his theory he

content before Morel. Rousseau is among those who uses it, meaning thereby that change brought about through the abandonment of a life close to nature, and with the natural scientist Buffon (1707–88) degeneration signified deviation, change, collateral branch or subrace. Nor in later times was the concept of degeneration exclusive to psycho- and neuropathology, but was used as an explanatory concept in biology, medicine, sociology, criminology and eugenics.

For a more comprehensive study of the idea of degeneration see Genil-Perrin (1913). Wettley (1959) and Wettley & Leibbrand (1961) give a capable presentation of the problem illuminated from a modern perspective. It is handled in a more cursory fashion by Walter (1956).

[5] Judging the conglomeration of ideas which was the theory of degeneration we should keep in mind that in Morel's time heredity was still a mystery. Those theories advanced in the area rested of necessity on a fragile empirical foundation, which made possible the most widely varying interpretations. Regarding the later 19th century theories of heredity see e.g. Ribot's doctoral dissertation, *L'hérédité psychologique* (1871–72). The fifth revised edition was translated into Swedish under the title *Själsegenskapernas ärftlighet* (1900). Théodule Ribot (1839–1916), the first of France's professors of experimental psychology (1885), was convinced of the dominance of heredity in most areas: "Heredity seems to us as a biological law, that is, as a law existing in all. - - - This law controls life in all its forms: vegetable kingdom, animal kingdom and the human race, both the healthy and the sick, both the physical and the psychic" (Ribot 1900, p. 125).*

In the question of the hereditary transmission of acquired characteristics and mental degeneration he followed contemporary French alienists.

limits the content of "degeneration" to those more constant deviations from the norm that he considered to be morbid. They might be acquired or hereditary.

What was new in Morel's theory was the idea that degeneration is progressive: "Degeneration implies morbid deviations from the normal human type, hereditarily transmissible and evolving progressively towards decay" (Genil-Perrin 1913, p. 54).* The law of progressive degeneration has thus often been called Morel's law (ibid. p. 57).

According to the theory, a morbid predisposition grew more pronounced from generation to generation, expressing itself not only in more serious degrees of the same symptoms but also in completely new ones. This was thought possible on the basis of polymorphic heredity and the successive deterioration was, among other factors, ascribed to the negative summation effect of two neuropathically tainted individuals begetting children together.

It may now be necessary to stop for a moment in order to summarize the ideas that are comprised in Morel's theory of degeneration. As far as I can see it contains at least three conceptions possible to discern:

1) Nervous and mental illnesses are in most cases hereditary; originally they are acquired but are then passed on by way of heredity (belief in the inheritance of acquired characteristics).
2) Heredity is polymorphic in this field.
3) The diseases will deterorate progressively, sometimes during an individual's life span but ordinarily from one generation to the next.

Progressive degeneration was first described in Morel's textbook *Traité des maladies mentales*, published in 1860. It is there linked to his other great contribution to psychiatric theory: a new nosology built on the supposed etiology of the diseases. Morel had, like many other psychiatrists, felt a growing dissatisfaction with the French symptom-based classification, and he felt the time was right for a new approach.

Morel divided mental illnesses into six major groups: (1) the hereditary insanities (*les folies héréditaires*); (2) insanities resulting from poisoning; (3) insanities as a result of transformations of the so-called major neuroses (hysteria, hypochondria, epilepsy); (4) idiopathic insanities (above all general paresis); (5) the sympathetic insanities, that is those that develop under the influence of other physical ailments; and finally (6) dementia.

This system of classification met immediate opposition, especially from the Germans (cf. Lange 1883, pp. 4 f.), and it was never widely utilized. This was in part because it totally broke with traditional ways of seeing, but of course many also hesitated in the face of its speculative character.

Morel's disease categories can be divided into two major groups: hereditary diseases and those caused by other factors. He divided the former, *les folies héréditaires*, which was considered to include most mental disorders, into four classes. These correspond to what he considered to be increasing degrees of degeneration (the idea of progression).

In the first class are to be found individuals with a normal intellect but with a so-called nervous temperament. They are marked by a sensitivity, irritability and impetuosity; it is a question of people who, though normally not considered to be ill, demonstrate characteristics which to the well-informed betray the initial stages of deterioration. In this class we find eccentrics and people with so-called *idées fixes*, such as paranoid fantasies, compulsion symptoms and phobias.

Progressive degeneration leads to anomalies of a graver nature in successive generations. We move to a second class characterized by "delirium of feelings and conduct with an apparent preservation of intellectual faculties" (Morel 1860, p. 540).* Thus in addition to character disturbances this group shows flaws of an intellectual nature, which are, however, often skillfully hidden by conversational abilities, artistic ambitions, etc. Many of the monomanias of the older psychiatry were placed in this category, e.g. homicidal monomania, cleptomania, pyromania, dipsomania, and also—of special relevance for our present concern—moral insanity.

Immediately evident in Morel's third class are defects of the cognitive sphere. Individuals with the accentuated hereditary taint that are considered to exist here, fall easily into a life of vagabondage and criminality. Some of them are precocious as children and many are seized in youth by serious mental illness which leads to dementia.

Finally, in the fourth group are to be found cretins, imbeciles and idiots. We have thereby reached the final stage of progressive deterioration, for these individuals are most often unable to pass on their inheritance of illness.

Morel worked much with the hypothesis that degeneration was reflected in physical and mental characteristics, so-called *stigmata degenerationis*.[6] As early as 1854 Moreau de Tours spoke of certain traits such as irritability, uneven humor, tics, stammering, etc. which might be signs of a disposition towards mental illness. According to him this disposition was hereditary. Morel, a student of

[6] The physical and mental signs of deterioration occupied much of the attention of theoreticians of degeneration, since it was hoped that it would be possible to employ these to diagnose and predict degenerative taint. Meyer (cf. section 6.2.1, below) made a critical review of the subject in 1896. He found that much which was considered to be degeneration stigmata must in fact be seen as variations within the wide area of normality, for "the so-called normal type is an arbitrary assumption and embraces a great number of physiological variations" (Meyer 1896, p. 345). He continues: "The practical value of our *present* knowledge of the signs of degeneration is perhaps overrated by those who believe they have found a scientific phrenology" (ibid.). For the author a scientific elucidation of the problem would require a solid statistical base, and he also presents a detailed proposal of what this base should contain and how it might be collected.

What are considered to be *stigmata degenerationis*? According to Meyer (p. 347) they were: (1) morphological deviations from the normal; (2) functional deviations from the normal; and (3) purely psychical stigmata. Group (1) includes deviations from the general proportions of the body, primarily perhaps asymmetries of the skull, forehead, jaws, teeth, lips, nose and ears. In group (2) are retarded maturational development, enuresis nocturna, stammering, etc. Category (3) comprehends deviations of habit and manner of thought and feeling. Here are gathered sexual deviations, an unbalanced mind, marked egoism, obsessions, periodicity of mental life, etc.

anthropometrics, was also interested in physical stigmata. Asymmetries in the skull, lobeless ears, clubfeet, extra toes and fingers were according to him such physical signs of degeneration.

How did the *physician* Morel react in the face of the assumedly devastating effects of degeneration? He was not totally pessimistic. Through intermarriage with healthy families degenerated lines could be imbued with "healthy blood". He also saw possibilities for turning the downward curve of degeneration through an improved upbringing and bettered social conditions.

3.2.3 Continuing Developments in France

After a time the central aspects of Morel's theory of polymorphic and progressive pathological heredity were generally accepted. It received, however, a certain amount of criticism, being rejected, according to Vestberg (1948, pp. 27 f.), with great force by Tigges as early as the end of the 1860s. Through statistical examinations of more than 3 000 mental patients Tigges had drawn the conclusion that heredity was probably not polymorphic in the area of mental illness. He rejected Morel's few genealogical investigations as lacking in evidence and hence worthless. However, the results of Tigges' research were not given the attention they warranted, probably because the doctrine of polymorphic heredity was already firmly established within neuro- and psychopathology by that time.

Considering its scientific stringency, Tigges' examination was in fact long before its time. In investigations concerning nerve pathological and psychiatric heredity during the latter part of the 19th century it was common to begin with an assumption that had in fact yet to be proved. It could for example be stated, as Trousseau did: "If a nervous disease appears in an individual and disparate varieties of this occur in his direct or collateral ascendants, then one is justified in assuming an hereditary relationship between those latter and the disease of the individual first named" (cited in Vestberg 1948, p. 28).*

The same mistake is made by Charles Féré (1852–1907) in his essay *La famille névropathique*.[7] By way of introduction he writes that the diseases of the nervous system, in so far as they manifest themselves through mental, sensory and motor ailments, "display numerous affinities and points of contact; despite the fact that in recent years clinical as well as anatomical-pathological studies have multiplied the number of species, it can still be said that they all compose a single family united by the indissoluble ties of the laws of heredity" (p. 1).*

Féré's essay was one of the most important works on polymorphic heredity and conditions of degeneration during the last decades of the 19th century and is often cited by contemporary authors.

[7] The actual expression *la famille névropathique* was probably borrowed by Féré from Moreau de Tours, in whose writings it appears.

Primarily for pedagogical reasons Féré divides the major neuropathic family into two groups: a *branche psychopathique* and a *branche névropathique*, but this does not indicate any weakening in the hereditary bonds between the two. He even claims that there are undecided boundaries between the neuropathic family and such varied phenomena as cogenital blindness, color blindness, wall-eye, albinism, deafness, hare lip, club-foot, scrofula, tuberculosis, rickets, rheumatism, gout and diabetes. Thus there is, according to him, a hereditary association, though perhaps a weak one, between these defects and the nervous and mental diseases.

The degenerated nervous system is the cause of practically all mental disturbances. Féré opposes the idea quite common earlier, that sexual excesses for example, or too intense intellectual activity could lead to mental disorder. For him such phenomena are rather signs of a neuropathic condition, but they can play a role as *agents provocateurs*, that is, as catalytic factors.

In the same year that an important debate was conducted by the *Société médico-psychologique* in Paris on degeneration (1886), another essential French work was released: Déjérine's (1849–1917) *L'hérédité dans les maladies du systéme nerveux*. According to Vestberg (1948, p. 28) this book can be considered to be "a codex of the doctrine of transforming heredity and its body of evidence".* The work takes up a number of genealogical compilations which according to its author demonstrate polymorphic heredity in the area of mental and nervous disorders. Its author holds the same opinions as does Féré, but deals to a greater extent with the problem of the origin of degeneration. In this question he represents an opinion which was general among theoreticians of degeneration at the turn of the century, namely that the origin is to be found in neurasthenia. The well known German psychiatrist J.P. Möbius (1853–1907) considered for example that neurasthenia was the "original slime" which was the basic element in a number of mental and neurologic illnesses (cf. Gadelius 1924, p. 405).

Weakness of the nervous system or, as the fashionable diagnostic term would have it, neurasthenia,[8] was thought to arise without the necessity of an hereditary

[8] George M. Beard (1839–83), New York physician and medical lecturer, described a nervous ailment in 1869 which he called "neurasthenia or exhaustion of the nervous system". The symptoms and signs he referred to this diagnosis had certainly been known long before, but he was the first to gather them under a single comprehensive concept, for which he coined the name neurasthenia. During 1880, 1881 and 1884 he developed his concept in widely read works. Among other things he claimed (1881) that the spread of neurasthenia had to a large degree to do with the rush and competition of modern life. This lifestyle was, according to him, characteristic of Americans, which was the reason that they especially were the victims of this ailment. Consequently he also called neurasthenia "American nervousness". The concept neurasthenia became extremely popular during the 1880s and 1890s, in spite of the fact that it was, as many pointed out, "a new name for an old illness" (Pontoppidan 1886, p. 17).* As early as 1893 Müller could compile several hundred references in his *Handbuch der Neurasthenie*. Soon, however, the concept was felt to be far too vague and comprehensive. During the 1890s Janet placed the anankastic forms of neurasthenia in a special category and called them psychasthenia, while Freud for his part wished to distinguish genuine, acquired neurasthenia from obsessive and anxiety neuroses. Neurasthenia was caused, according to Freud, above all by excessive onanism, while anxiety neuroses in the case

disposition. When it had developed, however, it could be passed on to coming generations in the form of a "neuropathic" predisposition. Thus was the process of degeneration a fact. This reasoning built of course upon the belief that acquired characteristics and diseases could be inherited, a conception very common among pre-mendelian heredity theoreticians.

Krafft-Ebing's reasoning on the question is typical of the times. He feels there is virtually no doubt whatsoever "that anything that weakens the nervous system or reproductive capacity of the progenitor, whether this might be extreme youth or too advanced age, undergone debilitating illnesses (typhus, syphilis, tuberculosis), mercury cures, alcohol and sexual excesses, over-exertion, etc. can result in a neuropathic constitution and through this lead to every possible nervous disease in the progeny" (Krafft-Ebing 1888, p. 178).*

The theoretician of degeneration who was to be the most significant in France after Morel was Valentin Magnan (1835–1916). Primarily a neuropathologist, he was interested in the organic aspects of psychic disturbances. Among other things he studied the effect of alcohol upon the human nervous system.

Magnan modified Morel's theories to a certain extent. He rejected for example Morel's religious perspective on degeneration, allying himself instead with positivism and Darwinism. However, he did adhere to the central theses in Morel's teachings, the opinion that nervous and mental diseases are to a high degree caused by polymorphic heredity, and that the morbid predisposition has a tendency to grow worse from generation to generation. Most of the indicated diseases were for him "functional or dynamic anomalies, deviations from the normal course of emotions or thought, which have their origin in a special brain structure. This in turn is only the result of a number of hereditary transformations" (Magnan & Legrain 1895, p. 44).* According to Magnan this explains why mental pathology manifests itself in such a large number of symptoms; it is a question of individual reactions to basically pathological nervous systems.

The predisposition itself is most often inherited but can also be acquired. Extreme and enduring injurious environmental influences can break down the resistive power of the nervous system, thereby creating a receptivity for nervous and psychic ailments. Indeed, what is meant within psychopathology with the word "disposition" or "predisposition", if not some form of reduced resistance of the cerebral organ (see ibid. p. 54)?

According to Magnan, those marked for mental illness are of two kinds: the simple predisposed and the predisposed with degeneration. The first-named group

of men was accredited to *coitus interruptus* (see Andersson 1962, pp. 118 f.). For an overview of the development of the neurasthenia concept see Bunker (1930).

Regarding Beard as physician and researcher Rosenberg writes (1962, p. 245): "His popularization of the idea of neurasthenia won him an international reputation in the late nineteenth century and has gained him the attention of historians of psychiatry in the twentieth - - -. Yet Beard was neither a profound nor a critical thinker. His medical writings are a mosaic of the fashionable and controlling ideas of his time; it was the familiarity, rather than the novelty, of Beard's theories which made them so easily and rapidely accepted".

is comprised of individuals who were considered to be fully normal before they displayed symptoms of mental illness. That disposition which, in spite of their apparent health, was the basis of their deviation—and according to Magnan, without such a disposition they would have remained healthy—is latent or weak and does not express itself through any specific personality traits. The psychoses exhibited by these people are thus of an uncomplicated nature. In the second group we find "the ill whose intellectual and moral personality has been fully transformed from the base, since birth, dependent on the actual progressive aggravation of the predisposing factor" (ibid. p. 59).*

The taint of degeneration follows the afflicted like an evil shadow, and its effects can be noted through his entire lifetime. From the very beginning development is disturbed: teething is difficult, the child learns to walk and speak late and shows nervous disturbances at an early age. Puberty is a difficult period, often with a number of sexual perversions establishing themselves. Later follows all the social stress of employment and marriage which so often becomes too much for these people.

According to Magnan the most distinctive mark of the degenerate is the lack of mental balance: "(Their) mental situation can be explained with a single phrase: the equilibrium between all the cerebral functions has been destroyed" (ibid. p. 61); in other words: "no degeneration without mental unbalance" (p. 64).

Magnan tries to relate this disharmony to the neurophysiological substrate. He writes about that (cited in Pichot 1978):

> Normally in the workings of the diverse centres along the cerebro-spinal axis exists a harmony, an equilibrium adequately proportioned to the integrity of these centres. - - - The characteristic feature of the degenerate's mental state lies in the disappearance of this equilibrium, this harmony of functioning between diverse centres.

Magnan considered it possible to determine the extent of the degenerative taint through, among other things, the intellectual level. The least degenerate class is made up of the intellectually gifted: "They comprise the original, the bizarre, the eccentric, which can be listed under the heading 'the unbalanced' (*déséquilibrés*) or 'superior degenerates' (*dégénérés supérieurs*)" (ibid. p. 65).*

This group gained a certain popularity among the educated of the period, and certain authors, for example Max Nordau (1849–1923)[9] and Möbius (cf. above)

[9] Nordau, who had changed his name from Südfeld, was born in Budapest of Jewish descent. He was educated as a physician but soon moved to Paris, where he devoted himself to, among other things, literary activities. He was among the pioneers of the Zionist movement and was a close friend of its founder, Theodor Herzl. In his critique of *fin-de-siècle* culture he attempted to show that it was primarily the product of degenerated individuals. Nordau's work *Entartung* (2 vols, 1892/93), translated into English in 1895 under the title *Degeneration*, drew much attention, also in America. In his writings it is stated that degeneration has spread like a plague through the culture-bearing levels of the population, and a number of contemporary authors including Tolstoy, Ibsen, Zola, Nietzsche and Wilde are pointed out as typical of this degenerated class. In America his ideas were recieved with mixed feelings and in 1896 there appeared *Regeneration—a reply to Max Nordau*, a savage response from an anonymous author. In the *American Journal of Insanity* the work was reviewed by the well-known neurologist E.C. Spitzka who was also very critical (see Spitzka 1895/96). Cf. also Walter (1956).

attempted to find in the ideas of degeneration an explanation for the not unusual combination of genius and disharmony among prominent artists, philosophers and authors.[10] For that matter Möbius is said to have considered himself a *dégénéré supérieur* (see Zilboorg & Henry 1941, p. 459). Lower down the scale we find as in Morel's writings, the feeble and imbecile, and at the bottom the worst grade of deterioration: the mental condition of the idiot.

Magnan also thought of unbalanced states affecting mainly the sphere of emotions and volition and resulting in e.g. mood swings, anancastic tendencies and excessive egoism. The latter has a connection to moral insanity (cf. section 4.1, below).

3.2.4 The Theory of Degeneration in German Psychiatry

Thanks to the interest shown by Griesinger, Morel's thought gained an early reception in Germany (Genil-Perrin 1913, pp. 135 f.). Later, the larger number of German neurologists and psychiatrists absorbed the basic aspects in Morel's theories. Among those influenced by the Frenchman was the prominent physician and author of text-books, Heinrich Schüle (1840—1916).

However, a name more familiar to posterity is that of Richard von Krafft-Ebing (1840—1902). He came to exercise great influence in the German-speaking world, and was often cited in the English literature as well. He is perhaps best

[10] Like Möbius, the philosopher and psychologist Axel Herrlin (1870—1937) would at the turn of the century demonstrate a connection between mental disturbances and that which we call genius. He writes (1903, p. 19): "Is it not conceivable that the constitution of organisms which under certain unfavorable conditions breaks into distinct forms of illness, could be transformed into other expressions of psychic life, not directly considered to be morbid? That for example the same family trait that in one individual can deteriorate into nonsensical delusions or mania, might in another only be admitted as a certain *liveliness* of imagination which perhaps also may result in valuable creations within literature and art".*

Moreau de Tours was the first to treat this theme in greater detail, in his *Psychologie morbide* (1859). Nothing can lead us more astray, he explains, than the old adage "a sound mind in a sound body". The healthy average person can have a good sense of judgement, but will never be great in crime or in goodness. "He is never struck by the disease of the mind which is called *genius*" (Herrlin 1903, p. 23).

Lombroso (see section 4.2, below), too, speculated on genius and mental illness. For his part he believed that the nervous constitution of a genius was closely related to epilepsy. Genius should in other words be a kind of epilepsy equivalent. Even the name given epilepsy in the Hippocratic writings, "the holy disease", pointed in this direction. To support his theory Lombroso claimed that many prominent men, Caesar, Mohammed, Petrarch, Peter the Great and Napoleon suffered from epilepsy (see Herrlin 1903, pp. 76 f.).

Möbius attempted, as had Magnan, to find in mental degeneration an explanation for genius. The characteristic of the degenerative state of mind was after all disharmony or *deséquilibration mentale* (Magnan). In line with this inference Möbius reasons as follows (1900, p. 121): "On one hand, if degeneration, through the languishing away of important impulses, may lead to a disharmony of mental powers from which crime emanates, so we see, on the other hand, that harmony is disturbed by development of certain capacities which must be seen as a gain".* In a number of writings Möbius attempted to explain, from this perspective, such spiritual accomplishments as those of Goethe, Schopenhauer and Nietzsche.

known for his great study of sexual deviations, *Psychopathia Sexualis* (1st ed. 1886), the standard work on the subject for many years. His *Lehrbuch der Psychiatrie* was printed in seven editions, the first in 1879 and the last in 1903. In this work one can see how influenced Krafft-Ebing was by the ideas of degeneration. For example, in the third edition one reads that there is a fundamental difference between a mental disturbance which arises in a brain previously healthy (a "robust" brain) and a disturbance in a brain which suffers from some sort of hereditary taint or has been negatively affected in another way during development (an "invalidized" brain; see Krafft-Ebing 1888, p. 318).

Like Magnan, Krafft-Ebing maintains this perspective when constructing his psychiatric classification. Thus he speaks of *Psychoneurosen* when it is a question of insanities where the cerebral function has been normal until the patient has fallen ill. On the other hand he speaks of *psychische Entartungen* (mental degenerations) when the diseases are "constitutional", that is based in the entire constitution of individuals "who have *ab ovo* or at least from early childhood betrayed the presence of a neuropathic constitution, and the functioning of whose central nervous system has always been in a state of labile equilibrium, which would predictably be disturbed" (ibid. p. 319).*

Theodor Ziehen (1862–1950)[11] and Emil Kraepelin (1856–1926) were somewhat more critical of the conceptions of the degeneration theory. Unlike Krafft-Ebing and the French, Ziehen considered it to be difficult and often impossible to decide whether a psychosis had developed on a so-called degenerative basis or not (Ziehen 1894, p. 215). However, he never questioned the great importance of a degenerated constitution as an etiologic factor in nervous and mental illnesses.

Kraepelin, the great name in German psychiatry in the decades after the turn of the century,[12] also became increasingly critical of the theory of degeneration. In

[11] Theodor Ziehen was a researcher with a variety of interests. He "was a philosopher by predilection and for many years a psychiatrist by training and occupation" (Boring 1950, p. 427). However, in 1912, he withdrew from the post of professor of psychiatry in Berlin to devote himself entirely to philosophy and psychology. During 1917–1930 he was professor of philosophy at the University of Halle. Ziehen wrote many books, among others a textbook in psychiatry (1894).

[12] Kraepelin is probably the most well-known psychiatrist in the world. Few psychiatrists or psychologists in our century could have avoided hearing of him. Above all he is known for his division of the endogenic psychoses into dementia praecox (later called schizophrenia after E. Bleuler) and manic-depressive illness. He is the last great system builder in psychiatry, representing the quintessence of organically-oriented psychiatry as it developed in mental hospitals during the latter part of the 19th century. Kraepelin's determination and diligence are famed. From the very beginning of his career—unlike many other distinguished psychiatrists—he intended to study psychiatry. He borrowed his psychology from Wilhelm Wundt (1832–1920), the great pioneer within experimental psychology. In the summer of 1877 he attended a course in experimental psychology conducted by Wundt, and five years later renewed his contact with him. Kraepelin was while still only 30 years old appointed professor of psychiatry in Dorpat. Four years later (1890) he was called to Heidelberg, and in 1904 was appointed chief of the psychiatric research clinic in Munich, where he remained until retiring.

Before Kraepelin psychiatric nosology was, according to Wernicke, "a misery" (cited in Meyer

his famous psychiatric textbook, printed in eight editions between 1883 and 1915,[13] one can follow his gradual liberation from this doctrine. As early as in the first modest edition, titled *Compendium der Psychiatrie*, he is critical of the French writers' submission of evidence in the question of pathological polymorphic heredity (Kraepelin 1883, p. 62). Nor does he consider it justified to use the presence or absence of "degeneration", i.e. degenerated constitution, as the basis of psychiatric classification.

In the fifth edition of the textbook (1896), now titled *Psychiatrie – ein Lehrbuch für Studierende und Ärzte*, Kraepelin carried out his radical amalgamation of a number of syndromes under the heading *Verblödungsprozesse*, that is, processes leading to dementia. "Dementia praecox" was placed here, as well as catatonia and dementia paranoides. The whole group would be called dementia praecox in the following edition (1899). However, the remarkable thing for our present context is that these syndromes were brought together with myxoedema and cretinism as well as with metabolic disturbances, and thus were seen as a group of illnesses that was not based on mental degeneration. Kraepelin would later revise his notion of dementia praecox being caused by endocrinous disturbances, but it still illuminates his gradual liberation from the idea of polymorphic heredity.

3.2.5 Reasons for the Decline of the Theory of Degeneration

What was it, then, that finally caused the theory of degeneration to appear in a new light, unmasked as the diffuse group of hypotheses it basically was? Several factors can be traced. Along with the hypothesis of polymorphic heredity which, since faith in Morel's progressive deterioration had weakened, stood as the central notion in the degeneration theory, there were also several theories of heredity which elevated the principle "like reproduces like". Darwin for example was promoting his "theory of pangenesis" at this time (cf. Geison 1969; Ribot 1900). Even among psychiatrists a discussion proceeded—quietly at first, but

1951f p. 527). With his system, then, he created an order which was of benefit to psychiatric science, though his diagnostic categories have recently been brought increasingly into question (cf. e.g. Braceland 1956/57)).

For a comparison of Kraepelin and Freud, both born in 1856 in the same linguistic and cultural world, and both prominent yet very different psychopathologic researchers, see Kolle (1957). This author, who sympathizes with Kraepelin's method of conducting research, is sceptical of Freud's teachings. On the other hand the American Zilboorg with his psychoanalytical background gives us another picture of Kraepelin. He appears in Zilboorg's description as a somewhat inhuman researcher who knew his patients' life histories and the course of their diseases, but in spite of this was foreign to their inner life, their individual personalities, those things that so interested Freud (see Zilboorg & Henry 1941, pp. 450 f.). As a matter of fact Kraepelin was not searching for the individual but the general, that which constituted *Krankheitseinheiten* (disease units).

[13] A ninth edition was being prepared at Kraepelin's death, and sections of it appeared in the year after with the cooperation of J. Lange (see Kolle 1956, p. 179).

becoming more intensive—as to whether or not certain mental illnesses did indeed show a uniform heredity. An increasing number of empirical investigations seemed to point in this direction.

Just before the turn of the century a genealogically interested historian, O. Lorenz (1832—1904) directed sharp criticism at those genealogical tables which built the supposedly empirical ground of, among others, the theory of polymorphic heredity (see Vestberg 1948, p. 30). He pointed to the fact that the quoted tables were pedigrees which began with an individual far back in time. But in order to demonstrate clearly a patient's inheritance we must, according to Lorenz, begin with him and thereafter branch out backward in time; otherwise we miss a large number of ancestors whose contributions to the germ plasma borne by the patient should not be neglected. Evidently Lorenz means that it is impossible to prove that a patient's illness derives from a certain ancestor, when, at the same time, one ignores a number of other ancestors, each of whom has supplied an equal share of the patient's germ plasma.

An increasingly important factor was the strictly empirical evidence of the new genetics. Gregor Mendel's (1822—84) laws of heredity, which had been long neglected, were revived at the turn of the century by Correns, de Vries and Tschermack, and there was new hope that the riddle of heredity would be solved in the not too distant future. Psychiatrists and neurologists were much impressed by the presented research results. Nor would it be long before they attempted to apply the theory of dominant and recessive heredity to such syndromes as schizophrenia and manic-depressive psychosis (cf. e.g. Rosanoff & Orr 1911).

3.3 Summary

Intensive psychological study of mentally disturbed individuals had gradually made it clear that mental illness most usually does not strike suddenly and unexpectedly. In the premorbid personality of the affected are often found traits which preceeded the onset of illness, and authors talked increasingly of a predisposition for mental illness. Similarly, there seemed to be a disproportionately large number of mentally ill or deviant personalities among the ancestors of the patient. Indeed, an increasing number of signs tended to prove, according to the researchers of the time, that insanity was hereditary.

The epoch-making work of Morel provided the break-through for the theory of heredity within psycho- and neuropathology. His genealogical investigations were certainly inadequate if judged by later standards, but they were accepted by psychiatrists and neurologists for more than a half century. Morel was convinced that heredity in the psycho- and neuropathological area was polymorphic. All the varieties of mental and neurological syndromes build, as Féré expressed it, one large neuropathic family bound by a common hereditary origin.

The notion of progressive degeneration was also associated with the work of Morel. It consisted of the idea that hereditary predisposition could, from genera-

tion to generation, undergo a deterioration, finally leading to the extinction of the affected family. Morel felt that he could see a law acting in this successive corruption which justified his speaking of four grades or classes of degeneration (*loi de Morel*). Many researchers were, however, not convinced by this strict law, and were subsequently increasingly doubtful. Still, it was possible for them to agree on the observation that unless fresh blood was infused into a neuropathic family, a gradual worsening of the germ substance was unavoidable.

France, home of the theory of degeneration, was also the country in which it had the greatest and most long-lived success. At the turn of the century it lived on in prosperous health, popularized as it was by Magnan and his co-workers. *Dégénérés supérieurs*, Magnan's designation for intellectually gifted but "neuropathically tainted" individuals, was a concept which had wide currency, not least among authors of fiction.

The theory of degeneration also had success in Germany, with adherents including Schüle and Krafft-Ebing. A growing spirit of opposition can, however, be noted earlier in the German-speaking nations than in France. In the 1880s and 1890s reservations in the face of certain of the ideas in the degeneration theory can be traced, for example in the writings of Kraepelin and Ziehen. A chief objection was to the fact that Morel, Magnan, Schüle and Krafft-Ebing built their psychiatric classifications on a base of alleged degeneration or non-degeneration (cf. Genil-Perrin 1913, p. 161).

During the first decades of our century the hypotheses of degeneration successively lost their grip on psychopathologists. A growing number of researchers demonstrated the serious flaws in the material upon which they were built. Yet above all it was modern genetics with its exact, empirically plotted laws that dealt the death-blow to this thinking.

This chapter may appear to the reader as too strong a digression from our theme. However, it has been necessary to carefully penetrate the different conceptions of the degeneration theory and their influence on psychopathologists of that time in order to understand the subsequent development in the area. This will be clear from the following two chapters.

4 "Moral Insanity" as a Form of Degeneration

4.1 French Views

As has been indicated earlier (cf. section 3.2.2), the concept "moral insanity" is found in the work of Morel as one of the syndromes in the second class of his *folies héréditaires*. He writes of the individuals in this class that insanity manifests itself in them more through deed than word; they can be distinguished "through their eccentricity, through their lack of consistency, their rulelessness and the often deeply immoral nature of their acts" (Morel 1860, p. 541).*

According to Lange (1883) the interest of Morel as well as of other contemporary authors is concentrated primarily on the disease variant moral insanity. This, says Lange, is in itself natural, and he states that among all the degenerative mental illnesses, moral insanity is certainly the one to attract most practical interest; though it is also the one most difficult to describe in distinct terms. He continues (ibid. p. 198):

> Its position can be described as being that unclear and only vaguely sketched border tract which lies within the sphere of degeneration closest to the boundary of the domains of normal existence.*

In those people who, according to Morel, suffer from *folie morale*, one often finds impulses towards generally evil actions. They frequently indulge in excesses of alcohol and sexuality, they have an instinctive need to torment anyone who is in any way dependent on them, and as chiefs they persecute their subordinates unmercifully, seemingly only to satisfy their perverse impulses.

At a superficial examination, these people exhibit no intellectual defects whatever. They may at times occupy prominent places in society, but it is not possible for them to accomplish any deed of lasting value, for they lack endurance. Additionally their mental life is prey to strong fluctuations, so that feverish activity often alternates with depression and passivity.

Certain of these individuals may show an aptitude for artistic or scientific activity, but if their accomplishments are examined more carefully, one finds that these reflect the falseness, vanity, bad judgement and inclination for paradoxes that mark their producers. By way of summary Morel considers that, to express it simply, they show "no consistency in their plans, no organization in their day-to-day lives, no sense of duty in matters concerning family and society" (Morel 1860, pp. 542 f.).*

Thus in the work of Morel we find moral insanity as one variation among many in the large group he terms *folies héréditaires*. He thinks the syndrome to be a special pathological reaction by a certain category of degenerates.

A more circumscribed and careful description of moral insanity is found in Campagne's *Traité de la manie raisonnante* (1869). The author builds firmly on the theory of degeneration but, unlike Morel, he claims that moral insanity, which he prefers to call *manie raisonnante*, is at least as simple to delimit as is progressive paralysis. For him the basis of *manie raisonnante* is the egoistic character and it is this that is passed down from generation to generation.

If two persons with this tendency bring children into the world, the line will infallibly degenerate, since one must reckon with a summation of bad tendencies. Campagne considers also that it takes four to five generations until a grave case of *manie raisonnante* occurs in a normal, healthy family. Happily enough the depressing trend of degeneration can be broken through intermarriage with healthy families.

It is then the absence of higher moral feelings which determines the development of antisocial and perverse traits in these individuals. Even as children they display an obstinacy, disobedience and stubbornness that parents can in no way influence, and they later behave in a similar fashion to their teachers and employers. Speaking generally, they lack respect for any sort of authority and when they sometimes do show any sort of consideration it is only to gain an advantage. They are well aware of their own rights, but on the other hand can mobilize no feeling for their responsibilities. They lack real friends, for such to them are those of whom they can take temporary advantage. They are naturally unable to experience love in any deeper sense than the purely sensual. At the lunatic asylums they are feared for the slander, the discord and squabbles they constantly provoke among their fellow patients, and their ability to escape in spite of minute surveillance and high walls is phenomenal. They are, as Campagne expresses it, the "true moral monsters, so far unknown within science, but which certainly deserve to figure among psychiatry's most sure, important and remarkable findings" (cited in Herrlin 1904, p. 149).*

In the question of their intelligence Campagne reasons fairly much like Morel. To the superficial observer they may sometimes appear brilliant, for they quickly pick up the ideas and opinions of others, have a lively imagination and sometimes also a good memory. Often they demonstrate a certain talent but seldom any deeper originality. As children some of them give hope of great deeds, but nothing ever comes of them, for they can not cope with systematic, logical work and thought.

People who suffer from *manie raisonnante* are characterized by an enervated will. Thus they can seldom endure the same job for any longer period and will gladly lead a nomadic kind of life. Those that have funds constantly travel about seeking new experience, while when poor they become tramps and beggars. The only therapy that Campagne can recommend in the case of these patients is "a mollifying iron hand" (Lange 1883, p. 224).*

Other French authors perpetuate this horrifying picture. In Cullerre (1890, p. 24), e.g., one reads:

Those suffering from moral imbecility exhibit from childhood evil impulses, corrupt emotions, ugly inclinations, impossible to control. They are fantastical, eccentric, lazy, quarrelsome, hot-livered and violent. Consequently they are expelled from all institutions to which they have been assigned. - - - Even the most conscientious and sensible upbringing that can be thought of has till now failed to improve depraved and sickly impulses, and has yet to transform an immoral degenerate into a virtuous human being.*

Magnan's view on moral insanity coincides to a great extent with that of Morel; he considers the syndrome to be a variant of the many syndromes that mental degeneration gives rise to. For Magnan the criterion of this state is an unbalance which can affect different aspects of the mind (cf. Magnan 1897, p. 171). When primarily the intellectual sphere is affected one has the pattern of a *manie raisonnante*, which, however, does not mean the same for Magnan as for Campagne. With this term Magnan refers to paranoid reactions by certain individuals as *chicaneurs, quérulants* and *procéssifs* (Magnan & Legrain 1895, p. 66). Finally, when the unbalance is one of the emotions and will, the syndrome of *folie morale* (moral insanity) will often appear. Magnan also notes that it seems generally accepted to consider moral insanity as a *malformation congénitale* (ibid. p. 27).

4.2 Lombroso: The Born Criminal

Cesare Lombroso (1836–1909) was an Italian physician who from an early date devoted himself to scientific activities. He was of a pugnacious nature and did not hesitate to put forth his often unpopular opinions. During the last decades of the 1800s his was a controversial name in the scientific world because of his theory of the born criminal (*delinquente nato*). Even today he is known primarily for this theory.

However, according to many, Lombroso has been unjustly judged. Ochs (1957) who has studied Lombroso's work in depth, emphasizes its agreement with the thought of the time. This is shown in part by the seriousness with which his theories were discussed (ibid. p. 17). It should not be forgotten, that Lombroso was in fact the one to initiate scientific study of the criminal. Therefore he is generally considered by historians to be the founder of modern criminology.[1]

It is of significance in this context that Lombroso's theories came to draw the attention of psychiatrists and of other professions to criminality and its possible ties to mental illness and abnormality. His *delinquente nato* greatly stimulated the debate on moral insanity during the decades before and after the turn of the century (cf. Steltzner 1911, p. 5).

[1] The term "criminology" came into use at a later date. It is considered to have been proposed by the French physical anthropologist Paul Topinard (1830–1911), as a comprehensive concept including criminal anthropology (with criminal psychology and criminal biology as important subbranches) and criminal sociology. According to Ellis (1910, p. 31) this was proposed at one of the criminal-anthropology congresses at the end of the 19th century. This should in that case be at the Congress of Rome, 1883, since Garofalo (b. 1852), jurist and student of Lombroso, had in 1885 published a work entitled *Criminologia*.

"The born criminal" is a central notion in Lombroso's work. He is said to have arrived at the idea when he had occasion (1859)[2] to study a cranium from a criminal and found certain traits which reminded him of a rodent cranium. When he later heard that it had been possible to document cannibalism in a prisoner, his belief was strengthened (see Herrlin 1904, p. 167). According to Lombroso *delinquente nato* was an inferior being corresponding to the savage or to our own far-removed forefathers. He was strongly influenced by evolutionism and saw in the pronounced criminal individual an atavism, a step back in development, approximately the same as when a domesticated pigeon sometimes has young that remind of the wild species from which it had developed.[3]

The basic idea in Lombroso's theory, that crime was biologically rooted, was completely in line with the positivistic natural science of the day. The higher nervous centers, that is, the biological substrata for ethical feelings and decisions, were considered to have developed in man at a very late date. With so-called savages and primitive people this development had not gotten as far as it had with civilized peoples. Accordingly, Lombroso could—ignorant of "savages" as he was—find many parallels between them and the extreme criminal: various ways of killing human beings, promiscuity, pederasty, inclination to tattoo oneself, etc.

In agreement with Haeckel's biogenetic law, that ontogenesis is an abbreviated and rapid recapitulation of phylogenesis, Lombroso would also link the born criminal to the childhood of civilized people. With normal children of culturally advanced races there is, however, always the seed of a full moral sense which is lacking in the born criminal. He is simply morally blind and accordingly will resist all attempts to bring him up properly. The higher nervous centres which in normal individuals exercise a restraint over the lower do not exist in the born criminal, and he may thus operate at will, without ethical considerations. The born criminal has then, as Lombroso sees him, no specific predisposition for crime per se, but his lack of a moral instance means that quite early in life he will come on to a collision course with the many regulations of a modern society. His social prognosis is therefore extremely poor.

[2] Notice that 1859 was the year in which Darwin's work on the origin of species was published.

[3] Lombroso was hardly the first to believe he had found a relationship between bodily characteristics and inclination towards crime. The physiognomists of Classical times and the romantics were his predecessors, not to mention the phrenologists. What was new in Lombroso's idea is that he presents the born criminal (*Homo delinquens*) as a special variety of *Homo sapiens*, characterized by special physical and mental qualities. The explanation that this special type of man was an atavism is also unique to Lombroso (cf. e.g. Genil-Perrin 1913, pp. 207 ff.; Koch 1894).

In regard to the question of pioneers in criminology the contributions of the German, Grohmann, deserve to be more widely acknowledged (cf. chap. 2, note 45). As early as 1819 he spoke of *moralischer Stumfsinn* (Grohmann 1819, p. 162), that is, a moral senselessness or moral imbecility as characteristic of serious criminals. He was probably the first to use the term. He also believed in morphological deviations of this group, e.g. in regard to the shape of the cranium (cf. Ellis 1910, pp. 32 f.).

Lombroso's view of a moral control rooted in the higher nerve centres and which he considers almost as a biological instinct (cf. Ochs 1957, p. 33) resembles Campagne's view of moral insanity or *manie raisonnante* (cf. section 4.1, above). And like Campagne Lombroso was in fact strongly influenced by the teachings of Morel.[4]

Lombroso was naturally interested in the physical and psychic stigmata that so occupied Morel and his followers. He carried out what were for the time extremely detailed and conscientious comparisons between the cranium measurements of the criminal and normal person. Thus he considered that he had found that the facial area of the cranium dominated to a greater extent in the criminals than in the normal population. With the normal, law-abiding citizen the brain area of the skull would be relatively more developed. Lombroso describes the physiognomy of the born criminal in the following manner (1887, vol. 1, pp. 231 f.):

> Generally speaking the ears of the born criminal are handle-shaped, with thick growth of hair on the head, sparse beard, sunken eye cavities, enormous jawbone, chin squared or jutting, broad cheekbones—in short a mongolian or perhaps a negroid type.*

When the author speaks additionally of disproportionately long arms, one senses that the enthusiastic Darwinist has our assumedly anthropoid forefathers in mind.[5] Lombroso considered that he was also able to find such physiological anomalies in so-called born criminals as poorly developed sense of pain and color blindness. Left handedness was common as was epilepsy.

The description of the mind of the born criminal is simply a reproduction of the picture of moral insanity we have become acquainted with earlier. He consequently lacks social feelings and feels no regret over his crimes. He kills in cold blood and then can, unmoved, relax and sleep or devote himself to eating and commerce with prostitutes and friends. Nor does he feel any great fear at the thought of his own death, but can until the end make coarse jokes about his own execution.

Here we arrive at the question of how Lombroso related the criminal individual to moral insanity. To begin with he saw *delinquente nato* as an independent category, but by the third edition of his main work, *L'uomo delinquente* (1st ed.

[4] Genil-Perrin (1913) has clearly demonstrated that Lombroso was greatly influenced by Morel. Nor was this denied either by Lombroso or his students. In 1900 an Italian author, Antonini, wrote in *Precursori di C. Lombroso* (cited in ibid. pp. 214 f.): "Morel's theories were quite simply completed, corrected, perhaps one might say sculptured or formed by Lombroso who, through an application of them to criminality, extended the problem of degeneration. With the aid of atavism he opened new horizons and threw new light over the philosophic and legal as well as the social sciences, and he also brought the honor of a famous school to Italy".*

[5] The Swede Gadelius (see section 5.2.5, below), sharply criticises Lombroso's theories and attempts to give a natural explanation for those unusual physical characteristics found by Lombroso in his criminals. Gadelius stresses that almost all of these individuals come from the lowest levels of society, where rickets and other illnesses flourish (Gadelius 1906, pp. 385 f.): "It is the fault of such circumstances that the criminal is indeed often a noticeable type, with coarse and ugly features, but this is an average type among these people, debased as they are through want, vice and every imaginable misery".*

1876), he had arrived at the opinion that this deviation was nearly identical with moral insanity (1887, vol. 1, p. 450). In accordance with that idea he calls the criminal nature as well as moral insanity a "masked epilepsy, an epilepsy without convulsions" (ibid. p. 518).[6]

As stated, Lombroso's teachings created lively debate within professional circles and also among the educated public. Sommer (cited in Ochs 1957, p. 168, note 20) attempted to bring some system into the increasingly disordered debate by arranging the problem in two main questions:

1) Does the so-called born criminal really exist?

2) If the answer to the question is "yes", does this inborn moral abnormality manifest itself in significant morphological characteristics?

One of Lombroso's most prominent German critics, Baer (1894), considered that there certainly were a greater percentage of physical deformations and other anomalies in the criminal than in the non-criminal, and this was especially true of serious recidivists. This does not, however, justify Lombroso's regarding the born criminal as a special human type. According to Baer such a criminal could not practically be delimited from the normal population and from other degenerative forms. This opinion was shared to a large extent by other contemporary German psychiatrists such as Koch (1894);[7] Näcke (1894, 1902); Kirn (1894); Bleuler (1896);[8] Kraepelin (1899, 1904); and Aschaffenburg (1906).

According to Kirn (1894, p. 705) the debate on the born criminal began quite late in Germany, to be more specific, in the 1890s. By then the subject had been discussed for a length of time in Italy and France.[9] At the criminal-anthropologic

[6] Lombroso's hypothesis of a relationship between criminality and epilepsy is considered by many to be inconsistent, if one considers that he explained *Homo deliquens* to be an atavism. Regarding his hypothesized link between genius and epilepsy see chap. 3, note 10, above.

[7] Koch especially criticised Lombroso's thesis that the born criminal was an atavistic phenomenon. Since 1874 he had himself collected skulls at his insane asylum, Zweifalten. He found 40 craniums among them which, according to Lombroso's definition showed atavistic characteristics, but only five of these were the skulls of criminals. Koch continued (1894, p. 21): "When one considers the different habitual criminals from the point of view of their mental condition - - - one finds some to be mentally healthy, and some psychopathic individuals. And among the psychopathic - - - criminals I find among others that type which Lombroso called the born criminal. I have neither seen nor been acquainted through described cases with any other sort of 'born criminal' than the psychopathic".* Concerning Koch's theories, see section 5.1.1.

[8] Bleuler, however, defends the concept *delinquente nato*, claiming (1896, p. 1): "Indeed, it is in fact of no practical significance whether there exists a criminal type in Lombrosos' sense or not; that which is important in his theory is the assertion that the criminal deviates, both physically and mentally, from the sound, honest type of average human being".* Concerning Bleuler, see chap. 5, note 23.

[9] A French contribution to criminology, *Psychologie naturelle*, in three thick volumes, was published as early as 1868 by Prosper Despine. This work certainly does not limit itself to criminological questions, but they occupy a prominent position.

The author, influenced by the theory of degeneration and also by faculty psychology, claims that criminals often suffer from *folie morale* which manifests itself partly through a moral insensitivity (*insensibilité morale*). This defect is probably caused by the fact that their moral sense (*sens moral*), which according to the author is like the conscience an inborn, instinctive characteristic, has not developed (see Despine 1868, vol. 1). Cf. faculty psychology in e.g. Rush, section 2.4.1, 2.4.3.

congress in Rome in 1883 Lombroso's theses were taken up with great enthusiasm by most of the participants. In Paris in 1889 the sceptics were in the majority and at the congress in Antwerp, 1892, the concept *delinquento nato* was according to Kirn completely dropped. This is, however, an exaggeration, for the expression born criminal lived on in the literature a good way into the 20th century, even if its meaning had naturally been altered considerably.

While it would draw out in time before discussion of the born criminal began in Germany, it can be claimed that there was no such discussion at all in the English speaking countries (cf. Ellis 1890, pp. 46 ff.). The first to take up the ideas and research results of the criminal anthropology school in a systematic manner was Havelock Ellis (1859–1939),[10] later to become known for his sexological researches. In the first edition of his *The Criminal* (1890) he seems very positive to Lombroso's theses but by the fourth edition (1910) he is more critical and adds that Lombroso has his inadequacies as a researcher. However, as a pioneer and generator of ideas he has, according to Ellis, been of great significance for criminological research (see Ellis 1910, p. 42).

4.3 The German Concept of Moral Insanity

As stated above (section 3.2.4), Schüle and Krafft-Ebing were greatly influenced by Morel's teachings. This is also reflected in their views on moral insanity. Schüle (1878, p. 256) speaks of "the hereditary neurosis", another name for the inherited neuropathic constitution. If the nervous system is exposed to hyper-irritation – onanism is pointed out by the author as being a common cause of this–the hereditary neurosis may break out into insanity. At this stage of degeneration the disorder will usually take the form of either *impulsives Irresein* (impulsive insanity) or *moralisches Irresein* (moral insanity). The latter condition is painted in the same lurid tones as had been used by Campagne (cf. section 4.1). He speaks for example of "ethical colorblindness" and sums up with the assertion that the morally disturbed are "enemies of all social life, infecting everything, undermining all harmony, either because they themselves do not have the ability to experience it, or because they have sunk too deeply into a diseased state" (ibid. p. 405).*

[10] British interest in criminality as an expression of degeneration can be found as early as in Maudsley (cf. section 4.4, below). He was obviously convinced of the existence of the "born criminal" and refers to a certain Thomson, who had worked with criminal anthropologic research in the 1860s. Thus Thomson was, in this respect, at least as early as Lombroso, whom he probably did not know. If he too was influenced by Morel is unknown. Maudsley writes (1874, pp. 29 f.): "All persons who have made criminals their study, recognize a distinct criminal class of beings - - -. - - This criminal class constitutes a degenerate or morbid variety of mankind marked by peculiar low physical and mental characteristics". And he continues: "Crime is often hereditary - - -. Just as a man inherit the stamp of the bodily features and characters of his parents, so he may also inherit the impress of their evil passions and propensities: of the true thief as of the true poet it may be indeed said that he is born, not made".

Schüle considers the old dispute as to whether moral insanity can occur without intellectual defect as unproductive and the result of an older speculative psychology: "Rather, what is of real importance is that the intellectual and moral lesions of the mind do not always and of necessity go hand in hand" (ibid. p. 399).*

Krafft-Ebing similarly interprets moral insanity as a special form of mental degeneration rather than a delimited mental disease; he considers it to be "a singular degeneration process of the mental sphere which effects the core of individuality, its emotional, ethical and moral relations" (Krafft-Ebing 1892, p. 292). In his earlier writings (cf. e.g. Krafft-Ebing 1882, pp. 97 f.) he places moral insanity in the category *psychische Entartungen* (mental degenerations) but in his text-book (1888) he transfers it to the group of mental retardations as a case parallel to intellectual retardation, and he now prefers the designation moral idiocy. This probably indicates that with the passing of time he began to see the moral insanity syndrome as a rather stationary defect. By way of analogy with oligophrenia he also speaks of several degrees of moral idiocy: *moralisches Schwachsinn* (moral imbecility) and *moralisches Blödsinn* (moral dementia).

If these conditions are now considered clinically, what seems to be characteristic is a more or less articulate lack of moral sensibility. The precepts of moral law can certainly be memorized but they are not followed by any sentiments. Thus they remain "inert notions, uselessly burdening the consciousness of the defective individual who does not comprehend how to conclude from them any motives or contra-motives for his doings" (Krafft-Ebing 1888, p. 711).*

In the intellectual sphere these individuals do seem to be intact, as long as one limits oneself to an examination of their formal logic. However, there are always defects of intelligence which will express themselves through their inability to complete any sort of education, to keep a job, and in their biased and eccentric ideas (ibid. p. 712).

Krafft-Ebing treats the forensic significance of moral insanity in his work *Lehrbuch der gerichtlichen Psychopathologie* (3rd ed. 1892). For those who view the problem superficially, the difference between the ordinary habitual criminal and the moral idiot seems non-existent. According to the author, however, it is absolutely basic. The one is, through a defective organization of the brain, unable to act morally, the other has, through a poor upbringing and/or volitional inclination towards vice, brought about his own immorality. For a criminal law which reckons with moral guilt it is important to be able to distinguish between these two types of criminal. This is the doctor's job. Some of the criteria which he should employ are as follows (Krafft-Ebing 1892, pp. 296 f.):

1) Descent from mentally disturbed, alcoholic, epileptic ascendants;
2) Demonstration of those anatomical and functional signs of degeneration ascribed to the conditions of mental degeneration in general;
3) Demonstration of vasomotor (alcohol intolerance) and motor (contractions, lameness, --- epileptic symptoms) functional disturbances.*

Other observations can be added, for example that the symptoms manifested themselves early and in spite of determined attempts at fostering did not disappear.

According to the author it is meaningless to offer therapy to these "savages in civilization". They should be confined to houses of detention for the protection of society. Only in certain cases (the torpid type) can a strict training over a period of years lead to the subject being passably able to take care of himself (Krafft-Ebing 1888, p. 714).

The concept of moral insanity was the subject of lively discussion in the German-speaking nations during the years around the turn of the century. The debate was obviously stimulated by simultaneously proceeding discussion of Lombroso's "born criminal" and partially coincided with it (cf. section 4.2, above). A detailed summary of the discussion appeared in 1899, by Erdmann Müller. His introductory material makes a valuable contribution to the history of the moral insanity concept.

As pointed out earlier (cf. section 2.6.3, above) the theory of monomania was rejected at an early stage in Germany. It then followed that Prichard's moral insanity concept, falling as it did within the frame of this French thinking, had little success there. Instead German psychopathologists paid attention to Herbart's psychology, which emphazised the "unity of mind".[11] Subsequently a line of psychiatric writers during the 1860s and 1870s rejected the idea of moral insanity as a delimited disease unit (cf. Müller 1899, pp. 330 ff.).[12]

At the same time the referred to syndrome was considered by an increasing number of physicians to be a congenital disturbance in moral development. "We owe this view", writes Müller, to the terms 'moral imbecility' and 'moral idiocy' " (ibid. pp. 332 f.). This statement is, however, questionable. In my opinion the relationship is rather the following. The occurrence of such expressions as moral imbecility etc. shows that distinctions were early made between moral deficiency as on the one hand manifestation of mental diseases and on the other of congenital

[11] However, the experimental discoveries of the brain centers resulted to a certain extent in a return to earlier points of view. It was most importantly Paul Broca (1824–80), French surgeon and anthropologist, who, through his investigation of motor aphasia discovered its localization in the brain (1860). The observations became important principally since they proved in a seemingly scientifically unimpeachable fashion that different segments of the brain had different functions. This was an idea that had been furiously rejected by many physiologists, such as the Frenchman Flourens (1794–1867), as a reaction to the theories of phrenology. A decade later (1870) it was possible for I.E. Hitzig together with G.T. Fritsch to localize the motor centers through electrical stimulation of sections of the cerebral cortex.

[12] Müller refers to works including the following: Casper, J.L., *Klinische Novellen zur gerichtlichen Medicin*, Berlin 1863; Liman, C.J., *Casper's practisches Handbuch der gerichtlichen Medicin*, 6. Auflage, Berlin 1876; Adrian, H., *Zur Frage vom moralischen Irrsinn und Verbrechenwahnsinn*, Berlin 1881; Leidesdorf, Sandon und die folie affective, morale der Franzosen oder die moral insanity Prichard's, *Wiener med. Wochenschr.* 1865; Knop, Ueber Moral Insanity, *Allg. Z. Psychiat., 31,* 1875, p. 697 ff.

defective states. As mentioned earlier (cf. chap. 2, note 45) Grohmann had coined the term *moralischer Stumpfsinn* (moral feeble-mindedness or imbecility), as early as 1819, and according to Müller (ibid. p. 333) Zeller had in 1848 made an attempt to demarcate the same concept.[13] In summary, however, Müller claims that the majority of German psychiatrists at the turn of the century were in agreement that moral insanity is a congenital mental disturbance: "Its significant feature is a lack of, or distortion of the moral feelings and ambitions" (p. 342).

As regards the question of whether an intellectual disorder occurs with moral insanity or not, there was still disagreement. In his review Müller finds there were three trends of opinion, two extreme and one intermediary. He sets up an opposition between the first two positions, the first of which posits that we are inevitably confronted with a case of feeble-mindedness, and asserts that the suffering has its base in this congenital deficiency. The other position is that—despite admitting feeble-mindedness in a number of cases—the intellectual abilities can vary within wide limits. Here the syndrome is considered to fall under the large domain of congenital degeneration. The third, intermediary position is according to Müller taken by most authors in the area. Schüle, Krafft-Ebing and Kraepelin for instance were of this group.

How does one account for this long-lived disunity? Näcke is probably right when he claims that "in the question of intellect we possess no 'standard' nor any uniform method for examination" (cited in Müller 1899, pp. 347 f.). This gives too free a rein to subjectivity. According to Näcke another contributing cause was the fact that concepts such as memory, knowing and intellect (*Gedächtnis, Wissen, Intellekt*) were often confused.

For Näcke it is clear that in as good as all cases of so-called moral insanity there are unevenness in the mental equipment. Alongside acuity in certain areas it is possible to see notably weak performance in others. Many persons exhibiting moral insanity are for example so unable to exactly recall events that one must

[13] The expression "moral imbecility" can in fact be found in Prichard's volume from 1835 (p. 10). However, it is only used once, as far as I know, and it is a translation of Heinroth's *moralischer Blödsinn*. Prichard was, as we know, not especially interested in congenital moral defects (cf. section 2.6.1, above). Ellis (1910, p. 33) finds this unfortunate, considering all the fruitless discussion that Prichard's concept of moral insanity gave rise to. He claims, however, that a contemporary of Prichard, the Englishman Laycock, used the term "moral imbecile". Burt (1926) maintains in a note (p. 14) that Laycock made a clear distinction between "the moral imbecile" and "the morally insane" in an article in the *Medical Times and Gazette* (1862), but despite close reading of the referred to article I have been unable to confirm the information. Burt has probably not checked this himself, but instead mistakenly combined the two pieces of information about Laycock which are found in Ellis (1910, pp. 33, 72). He certainly does not cite him, but much points to the information having been taken from Ellis' well-known work.

According to the Danish psychiatry historian Beyerholm (1937, p. 249) the expressions *moralsk Idiotismus* (moral idiocy) and *moralsk Svaekkelse* (moral imbecility) are to be found in a work of the Briton David Skae, *The Classification of the Various Forms of Insanity on a Rational and Practical Basis* (1863). Cf. also Zilboorg & Henry 1941, p. 420. Maudsley, finally, whose first work was published in 1867, often uses the term "moral imbecility".

term the inadequacy an intellectual defect. With some this inability is so severe that it is possible to speak of *pseudologia phantastica*.[14] At one point, however —and here all concerned authors are unanimous—those suffering from moral insanity show an amazing capability. They are masters at defending and excusing their misdemeanors. As Müller writes (1899, p. 349):

Through generally acceptable motives they know how to explain their behavior and are quite capable of asserting themselves in the face of stringent logic (thus the name *Folie raisonnante*; Baillarger).*

Näcke (1902) believes that a genuine moral insanity might possibly exist, but only in extremely rare cases. He considers it then to be an isolated defective ability to experience emotions without any equivalent intellectual disturbance. Practically all cases of alleged moral insanity can therefore in Näcke's opinion be divided into three groups (ibid. p. 29):

1) Imbecility;
2) Mental degeneration in Magnan's sense, that is *dégénéré supérieure*;
3) Periodic or cyclical anomalies of mood.

Many cases of moral insanity belong to the first group. However, it is the moral rather than the intellectual defect which is prominent. An equally large group is at base degenerated, among these being found many cases in which the father's alcoholism is a probably cause of the degeneration. Also they often exhibit mild obsessive symptoms, mood swings, delusions and temporary psychoses. The third group is quite small and includes milder grades of periodic mood swings: "This group could perhaps be included in the manic-depressive insanity, though only in its most mild variations with predominant ethical defects" (ibid. p. 32).*

In the first edition of his textbook (1883) Kraepelin speaks of *moralisches Irresein* (moral insanity) as a condition of mental weakness alongside intellectual retardation and constitutional neurasthenia. Research has taught us, he claims, that a retardation can also primarily affect the emotions and therewith related actions, while the intelligence is seen to be undisturbed. The significant characteristic of *moralisches Irresein* is "the want of or weakness of those counter-motives which prevent the social being from ruthlessly satisfying his immediate egoistic impulses" (ibid. p. 352). This leads to the personality of the individual being marked to a large degree by elementary impulses.

Kraepelin changed his classification system for the third edition of his text

[14] In 1891 the Swiss, Anton Delbrück, published an academic treatise called *Die pathologische Lüge und die psychisch abnormen Schwindler*, in which he describes a number of cases characterized primarily by a disposition to reinterpret reality to an exceptional degree and place themselves in an advantageous light. He found that these symptoms could be seen in individuals with different diagnoses, among others, moral insanity. However, the special nature of the symptom marked the entire personality and in his opinion motivated its having an independent diagnostic designation. The name Delbrück proposed was *pseudologia phantastica* (Delbrück 1891, p. 130), which is still used.

(1889), but *moralisches Irresein* is still considered a special kind of mental retardation. In the sixth edition (1899) he abandoned the term *moralisches Irresein*, speaking instead of *moralischer Schwachsinn* or *der geborene Verbrecher* (moral imbecility and the born criminal). Otherwise the description of this disturbance is in accordance with what has been cited earlier.

In the eighth edition (1915, vol. 4) Kraepelin finally allows the moral insanity syndrome to be the major constituent of one of his seven groups of psychopathic personality. Different traits of this syndrome occur in other psychopathic groups, but the basic combination has been gathered by the author into the category *die Gesellschaftsfeinde* or *die Antisocialen*. He characterizes the group by a general inability, based on an underdeveloped emotional life, to respond to the ethical demands of human society (see ibid. p. 2103).

Kraepelin's treatment of the moral insanity syndrome can be said to be representative for the German-speaking authors in the field from 1910 onwards. It is handled within the frame of the general concept "psychopathic constitution" or "psychopathic personality", which was used with increasing frequency at that time. Now and then the expressions moral insanity, *moralischer Schwachsinn*, etc., seem to be required, but the authors prefer to place them within quotation marks and would rather employ newly-created terms (cf. e.g. Bleuler 1918, p. 445).

4.4 Developments in Great Britain after 1860

Among British psychopathologists it is, after Prichard, first Maudsley who is of interest for the present study. Son-in-law of the psychiatrist John Conolly (1794–1866), who had been famed for his philosophy of non-restraint, Henry Maudsley (1835–1918) was an intelligent and diligent person who wielded a skillful pen. He was only 32 when he published his great *Physiology and Pathology of Mind* (1867), which was a thorough success, published in several revised editions. He also wrote books and articles dealing with other questions, such as forensic psychiatry, and was soon considered to be a psychiatric authority far outside his country's borders.[15]

Maudsley's early scientific path coincided with the exposure of evolutionary theory to the public eye and with Morel's theories. These teachings came to greatly influence his view of man and of psychiatry. In spite of the influence of Morel, which is in evidence in for example the description of what Maudsley calls "the insane temperament", by 1879 he had little of Morel's interest in creating an etiological nosology. He himself employed a psychological and symptomatic

[15] According to Harding (1975, p. 52) it seems that August Strindberg was one of those who read Maudsley with great interest, as is shown by the essay *Själamord* (1887). Regarding Maudsley's life and work see Lewis (1963).

classification closely related to those of Esquirol and Prichard, explaining: "It is good so far as it goes, but it by no means goes to the root of the matter" (Maudsley 1879, p. 297). It has the following appearance (ibid. p. 329):

1) Affective insanity (insanity of feeling and action);
   (a) Instinctive insanity;
   (b) Moral insanity;
2) Ideational insanity (intellectual insanity) with different subdivisions of little interest here;
3) Amentia;
   (a) Intellectual imbecility and idiocy;
   (b) Moral imbecility and idiocy;

It appears from this schema and of course from the following commentaries that Maudsley makes a distinction between affective disturbances as an expression of disease (cf. above, point 1b: moral insanity) and as an expression of congenital or early acquired retardation (cf. above, point 3b: moral imbecility and idiocy).

Moral insanity is, according to Maudsley, that special form of mental disorder which greatly resembles vice. Many believe that this disease is a groundless medical invention. He, however, has another opinion (Maudsley 1874, pp. 68 f.):

> Notwithstanding prejudices to the contrary, there is a disorder of mind in which, without illusion, delusion, or hallucination, the symptoms are mainly exhibited in the perversion of these mental faculties which are usually called the active and moral powers—the feelings, affections, propensities, temper, habits, and conduct. The affective life of the individual is profoundly deranged, and his derangement shows itself in what he feels, desires, and does. He has no capacity of true moral feeling; all his impulses and desires, to which he yields without check, are egoistic; his conduct appears to be governed by immoral motives, which are cherished and without any evident desire to resist them. There is an amazing moral insensibility. The intelligence is often acute enough, being not affected otherwise than in being tainted by the morbid feelings under the influence of which the persons think and act; indeed they often display an extraordinary ingenuity in explaining, excusing or justifying their behavior, exaggerating this, ignoring that, and so colouring the whole as to make themselves appear the victims of misrepresentation and persecution.

Maudsley considers moral insanity to be only a syndrome which can indicate the onset of a more serious psychic ailment. As pointed out above the syndrome can also occur in a congenital form (moral imbecility and idiocy). He writes of children born with this defect (1879, p. 289):

> Afflicted with a positive moral imbecility, they are inherently vicious; they are instinctive liars and thieves, stealing and deceiving with a cunning and a skill which could never be acquired; they have no trace of affection for their parents or of good feeling for others; the only care which they have is to contrive means to indulge their passions and vicious propensities, and this they will do with singular ingenuity and acuteness. Intellectually some of them are defective also - - -. Others show no evident defect of intelligence.

After puberty it usually goes badly for these individuals. They incline increasingly towards evil tendencies, and if members of the lower classes of society,

they soon populate the prisons. Maudsley is even ready to call this group of people "born criminals" (cf. note 10, above).

With his evolutionist views, Maudsley felt that the goal of man's development was to attain harmony with nature and especially with his fellow man. The ability to feel sympathy is the most recent evolved quality in this process. That individual who is not capable of developing a positive feeling for the society to which he belongs, but is driven instead by his own egoistic motives at the cost of the welfare of others has already taken the first step towards degeneration (ibid. p. 102):

> Good moral feelings is to be looked upon as an essential part of a sound and rightly developed character in the present state of human evolution in civilized lands; its acquisition is the condition of development in the progress of *humanization*. Whosoever is destitute of it is to that extent a defective being; he marks the beginning of race degeneracy.

And the author continues (ibid.):

> Whether the particular outcome of the morbid strain shall be vice, or madness, or crime will depend much on the circumstances of life, but there is not doubt in my mind that one way in which insanity is generated *de novo* is through the deterioration of nature which is shown in the absence of moral sense. It was the last acquisition in the progress of humanization, and its decay is the first sign of the commencement of human degeneracy.

Thus the meaning of the concepts moral insanity and moral imbecility (or moral idiocy) as pronounced abnormalities of personality with ethical inferiority was further consolidated in Great Britain by Maudsley. He also makes a clearer distinction than earlier authors in the field between the moral insanity syndrome as expression of illness and as an early acquired or most often hereditary defect.

A different sort of person is the British psychiatry professor Tuke,[16] who has, however, an opinion similar to that of Maudsley in regard to etiologically-based psychiatric classifications. He willingly admits that Prichard's concept has been the cause of heated discussion, but in spite of that he bursts out, like a certain Latham, with: "Let those who doubt its value try to do without it" (Tuke 1882, p. 454). It has, he claims been the case that many, for example Krafft-Ebing, who do not accept Prichard's psychology, have still been compelled to use the much decried concept moral insanity (ibid. p. 455). Tuke considers that the variety of views on this disorder depend on "the want of definition of the terms employed in discussing the question" (Tuke 1892, p. 814). He continues (ibid.):

> Probably those who entertain different views on moral insanity would agree in their recognition of certain cases, as clinical facts, but would label them differently.

[16] Daniel Hack Tuke (1827–95) was the great grandson of the Quaker William Tuke, founder of York Retreat (cf. section 2.4.2, above). He had himself lived at "The Retreat" during a period of illness and physical weakness in his youth. Family tradition as well as a close acquaintanceship with the mentally ill during the period of his stay should, according to Zilboorg (1941, p. 420) have given Tuke an insight into their world, unusual compared with other psychiatrists of the time. His interest in the individual caused him, unlike for example Kraepelin (cf. chap. 3, note 12, above) to work more with practical care of patients rather than with research.

Why then do certain physicians refuse to accept the concept of moral insanity? The most common reason is, according to Tuke, the following (ibid.):

> In the vast majority of the cases of alleged moral insanity, very careful inquiry proves that there is congenital or acquired intellectual weakness. Hence it is safe to infer that such mental disorder would be found in all cases whatever, provided thorough investigation were carried out by competent experts.

But the important thing for Tuke is the clinical fact "that cases arise in which the stress of the disease falls on the moral nature, while those faculties, which are generally regarded as reasoning and perceptive, are so little, if at all, deranged, as not to attract attention" (ibid.). He means then that the concepts moral insanity and moral imbecility—the distinction between the two is not developed (cf. Tuke 1885/86, pp. 181, 185, 187)—are justified, and he also attempts to show that the philosopher Herbert Spencer, too, is of this opinion.[17]

In a contribution to the debate on moral insanity in the *Journal of Mental Science* (1885/86) Tuke distinguishes three clinical groups, all of which are in his opinion variants of moral insanity (p. 181):

1) Moral insanity as "a constitutional defect in the normal balance between the passions and the power of moral control or will";
2) as a change of character as a result of illness or moral chock;
3) as an isolated emotional disorder such as an intense depression "without the patient himself being able to formulate definite delusion".

It is clear from the above that Tuke is attempting to maintain Prichard's widely comprehensive definition of moral insanity (see section 2.6.1, above). Consequently he employs the names emotional insanity and affective insanity as synonyms for Prichard's term. On this point Tuke differs from Maudsley. However, his attempt was doomed to failure. "Moral insanity" had for a considerable length of time had a more limited and specific content than that which Prichard had once ascribed to it.

Tuke's attempt to explain the moral insanity syndrome is of some interest. He considers the term itself to be unfortunate, in that it leads people to believe that there is something wrong with the feelings per se in the affected patient. According to Tuke this is not necessarily the case. He continues (ibid. p. 183):

[17] Tuke had asked Spencer how he stood in the moral insanity problem, since in his psychology he stresses that it is impossible to completely separate congnition and the emoitons from each other. Spencer's response, which did not contradict Tuke's opinion, was the following: "Every complex aggregation of mental states is the result of the consolidation of simplier aggregations already established. This higher feeling is merely the centre of coordination through which the less complex aggregations are brought into proper relation - - . But in this evolution it is obviously possible that this centre of coordination may never be developed; what Spencer calls the higher feeling, or most complex aggregation of all, may never be reached in the progress of evolution, and moral imbecility may be the result, or such waywardness of moral conduct from youth upwards as it is maintained occurs without marked disorder of the intellect" (Tuke 1885/86, p. 187). Cf. Spencer 1881, vol. 1, pp. 575 f.

It suffices to hold that the highest level of evolution—that which Jackson termes provisionally "the most voluntary"—is affected, and that here we witness only the unchecked action of the lower level, consequent upon the dissolution of the higher. Thus the positive symptoms which we witness are themselves healthy: they are only out of proportion. - - - If in consequence of the driver of a coach being drunk, or asleep, the horses run away, it is obvious that they are healthy enough; the cause of their running away rests with the man who is no longer able to hold the reigns.[18]

4.5 Summary

Morel made moral insanity in its more limited, crude sense into a member of the large degeneration family. Its ultimate cause is in his view a neuropathic predisposition. With *folie morale* (moral insanity) degeneration has progressed so far that one can speak of a real mental disease (the second class of Morel's *folies héréditaires*). Due to the considerable practical as well as theoretical interest moral insanity had for decisions of forensic psychiatry, many authors occupied themselves to a considerable extent with this disturbance.

As might be expected descriptions of the concept differ from author to author during the half century that has been treated in the present chapter. However, there is throughout an assertion of the evil, false, egoistic, and often aggressive nature of the morally deranged or imbecile. In most cases he is made out to be a real "moral monster", as Campagne expressed it. Another metaphoric expression of the time was Schüle's "morally colorblind". Both of these designations imply a congenital, irremedial moral defect, and the therapeutic pessimism in regard to these individuals is nearly total.

According to the moral and judicial views of the time it was important to distinguish between criminality or evil as an expression of mental derangement on the one hand or, on the other, as the emanation of a moral corruption. For many lawyers moral insanity was never more than "a groundless medical invention" (Maudsley 1874, pp. 68). However, psyciatrists such as Maudsley (1874) and Krafft-Ebing (1892) devoted much energy to clarification of the distinction just mentioned and to finding criteria to determine when a moral insanity could be considered to exist.

Morel's view is reflected in German psychiatric literature to an increasing extent during the 1870s and 1880s. The two influential figures in psychiatry, Schüle and Krafft-Ebing, follow the Frenchmen in most important respects. The later writings of Krafft-Ebing do perhaps show a certain liberation from the French school; in his descriptions of moral insanity he there emphasizes its character

[18] J. Hughlings Jackson (1835–1911) was one of the great neurologists of the latter half of the 19th century. He was occupied by, among other things, epilepsy and has described so-called Jackson's epilepsy, that is, isolated cramps in certain muscle groups caused by diseased centers in the cortex. Biographical data on Jackson is found in *Grosse Nervenärtzte*, Vol. 1, published by Kolle 1956, pp. 135–144. The article is written by G. Holmes. Cf. also Ey (1961/62).

of a stationary, hereditary mental deficiency (*moralische Idiotie*). This view is somewhat different from the French one.

Later authors such as Kraepelin, Ziehen, Koch, Näcke, Bleuler, Aschaffenburg and others, prominent within German psychiatry during the years just before and after the turn of the century, free themselves to an even greater extent from the doctrine of degeneration, especially the hypothesis of progressive deterioration. Moral insanity is also for them primarily a hereditary defect.

The term moral insanity (including its German synonyms) was rejected now as being implicated with disparate and obsolete ideas. Certain notions central to the concept did, however, live on in a new shape, namely as some of the psychopathic types presented in ever-increasing numbers during the first three decades of this century (cf. chap. 5, below). An example can be seen in Kraepelin's "the anti-social" (1915).

Lombroso, whose primary interest was centered on the criminal, stated initially, that his category "born criminal" should not be confused with moral insanity; he considered them to be two separate concepts. *Delinquente nato* was seen as an atavistic phenomenon, an example of *Homo sapiens* at a less developed stage. As criticism of his imaginative hypothesis increased, however, Lombroso grew more inclined to accept the parallels between the two concepts.

Certain of Morel's ideas were promoted in England, especially by Maudsley. He distinguishes between the morally insane as a symptomatic class of the mentally ill and those who had already exhibited the syndrome in early childhood. He calls the latter moral imbecility or moral idiocy.

French psychiatry never had, during the time referred to here, a real impact in Great Britain. The British psychiatrists were less somatically oriented than their colleagues on the continent and less fascinated by the theoretical side of psychiatry. Questions of actual care seems closer to the hearts of those concerned. Tuke is a prominent representative of this tradition. He made various attempts to maintain Prichard's old definition of moral insanity—attempts doomed to failure, for developments had long since taken another direction.

In the German as well as the English-speaking countries there was constant debate during these years as to whether moral insanity really existed in its more original meaning, that is, if emotional and conative functions could be disordered without intellectual disturbance also being the case. As in the case of so many other controversial questions, the view which was to attract an increasing number of adherents, took the form of a compromise. Certainly it was possible to find inadequacies of logic in cases of moral insanity, that is disturbances of intellectual activities in a wider sense, if one did carefully search for them, but it was still considered that the emotional and conative disturbances of these individuals sharply contrasted with an apparently normal intellectual functioning.

5 Developments of the German Notions of Psychopathy

5.1 Initial Phase

5.1.1 Koch: Psychopathic Inferiorities

During the 19th century knowledge of mental disturbances increased enormously. A continuously rising number of symptoms and syndromes were described in a growing stream of psychiatric journals, monographs and texts. Against this background it is easy to understand the constant attempts to build a classification that would correspond closely enough to facts to be accepted by most psychiatrists, thereby bringing order to the nosological, communicative chaos of the time.[1]

The German psychiatrist J.L.A. Koch (1841–1908) was among those with this ambition. Additionally he had taken it upon himself to inform the educated public as well as the general medical practitioner about psychiatry in an easily comprehended fashion (see e.g. Koch 1880). In 1888 the book was published that would place his name in the annals of psychiatric history: *Kurzgefasster Leitfaden der Psychiatrie.*

Influenced by contemporary ideas of a close relationship between a number of mentally abnormal conditions (cf. section 3.2, above), in his book Koch gathered together all the conditions in the area between clear mental illness and health, in a widely comprehensive group called *psychopathische Minderwertigkeiten* (psychopathic inferiorities).[2] The theoretic motivation for approaching the problem

[1] "The search for a proper classification of mental diseases became a search for an understanding of a rich experience requiring synthesis", writes Zilboorg (1941, p. 420). When Boissier de Sauvages, Erasmus Darwin and Carl Linnaeus had, a century before, attempted to systematize psychic ailments their motive was in part another (cf. Zilboorg & Henry 1941, p. 419; also chap. 2, note 28, above).

[2] As far as I have been able to determine the term psychopathy (and also the expression psychosis) were introduced in psychopathology by the physician and author Ernst von Feuchtersleben (1806–1849). This occurred in his noted *Lehrbuch der ärztlichen Seelenkunde* (1845), translated into English two years later under the title *The Principles of Medical Psychology*, which was in fact the first psychiatric textbook published in Austria (see Harding 1975, p. 66). The term sporadically appeared in psychiatric literature until it was finally established through Koch's works.

In 1868 Griesinger published a famous lecture dealing with the compulsive need to interrogate oneself; here for example the term is found in the title which runs: *Über ein wenig bekannten psychopathischen Zustand.* In this context it should not be forgotten that Krafft-Ebing's widely distributed *Psychopathia Sexualis* was published in 1886, several years before Koch's *Leitfaden.* This

in this manner was that it dealt with abnormal conditions which were not really diseases (see Koch 1888, p. 35).

But just as one could not speak of disease in regard to these conditions, they could certainly not be associated with mental health. However, there are no distinct boundaries; psychopathic inferiority blends eventually into the broad channel of normality, just as, at the other direction, it may increasingly be characterized as an illness. It is the difficult task of the psychiatrist to judge where the line between the normal and the psychopathic is to be drawn. Only if he takes the entire life history of the relevant individual into consideration may this be accomplished.[3]

probably contributed to making the term familiar and usable for those in the profession.

Alongside "psychopathic" the term "neuropathic" was also employed and was initially much more common; as we know, a neuropathic tendency was often discussed in connection with the theory of degeneration (cf. section 3.2.3, above). When the expression neuropathic was used around the turn of the century the emphasis was placed on the "nervous" or neurological side of the disturbance, while with "psychopathic" the psychic or mental symptoms were emphasized.

In his psychiatry textbook (1894, p. 219) Ziehen uses the expression *psychopathische und neuropathische Constitution* on several occasions. This linguistic combination is in my opinion a manifestation of the "term shift" that took place in German psychiatry during the course of the 1890s. The "French" concept "neuropathic" was to a certain extent abandoned in favor of the new, "German" and probably somewhat more circumscribed concept psychopathic. As will be seen in section 5.1.2, below, Ziehen, like other German authors in the area later shifted to speaking only of "psychopathic" e.g. "psychopathic constitution".

In accordance with what has been said above the terms psychosis and neurosis were also employed. It was first through psychoanalysts that the term neurosis obtained the content it has today, that is, a personality ailment without an assumed neurological disorder as a basis. The metamorphosis to the present sense came about via the expression psychoneurosis, a term Freud had possibly borrowed from Krafft-Ebing. Cf. Andersson 1962, p. 56; Binder 1960, 1962; Schäfer 1972. Regarding the early history of the neurosis concept see J.S. Maier, *Beitrag zur Geschichte der Neurosenbegriffe von 1778–1887.* (Diss.) Erlangen.

Around the turn of the century (1900) the term psychopathy largely maintained its original meaning of psychic ailment in general (cf. Greek *psyché*, soul and *páthos*, suffering). Subsequently as it was increasingly employed in the combinations "psychopathic inferiority", "psychopathic constitution", "psychopathic personality", etc., a shift in meaning took place. As early as the 1910s this alteration of meaning had gone so far in the German speaking nations that the term psychopathy could be used synonymously with the expression psychopathic personality and other similar denominations.

In Great Britain this development proceeded considerably more slowly. Burt (1924, p. 12) for example emphasizes that he uses the word in its original meaning, but at the same time he is aware of its new content in German psychiatry. It is first through Henderson's (cf. below, section 6.1.2) concept "psychopathic states" that the attributive psychopathic aquires a specific content distinct from the original, even in Britain.

The change took place more rapidly in America. There the term psychopathy was accepted early (cf. section 6.2, below). The French on the other hand seem to have preserved the original meaning of the word (cf. section 5.2.4, below).

Along with the described shift in significance the term psychopathy has also acquired a negative emotional charge—especially among laymen. Regarding this development see section 5.2.3, below.

[3] Koch points out that there are also many somatic phenomena which indicate psychopathic inferiority, and it is of value to be aware of these when uncertain of the diagnosis. People with a psychopathic constitution tend to react convulsively in childhood, they show high intolerance to alcohol, are often sexually abnormal and often exhibit a number of physical defects and malformations. Here Koch draws on Morel and names some of his "stigmata" as for example asymmetries in cranial bones, uneven teeth and so-called Morelian ears.

More exactly, what is "psychopathic inferiority" for Koch, and what causes it? Like Schüle and Krafft-Ebing for example (cf. section 3.2.4, above) he believes that the conditions he refers to derive from a constitutional weakness or fragility of the brain. This results in the brain readily reacting in an inadequate or abnormal manner to strain which could be coped with, without difficulty by a normal, robust brain (ibid. p. 38).

Koch divides psychopathic inferiorities into two groups: congenital and acquired. He considers, however, that this division is not easy to follow in practise, since the forms often mix. Congenital inferiority is commonly hereditary but can also be caused by injury during the prenatal period, for example if the pregnant mother is exposed to great strain or leads a dissolute existance.[4]

The author further divides psychopathic inferiorities into three classes, depending on the seriousness of the brain's weakness. If all of his distinctions are taken into account the following schema results:

I. Permanent psychopathic inferiority
A. Congenital states
   1) Congenital psychopathic disposition
   2) Congenital psychopathic taint
   3) Congenital psychopathic degeneration

B. Acquired states
   1) Acquired psychopathic disposition
   2) Acquired psychopathic taint
   3) Acquired psychopathic degeneration

II. Temporary states of psychopathic inferiority

Koch does not have much to say about the mildest form, psychopathic disposition; it is sometimes difficult to discover and may in many individuals exist in a latent form for years.

The somewhat more serious grade, psychopathic taint, expresses itself primarily through isolated symptoms and a generally high responsiveness and irritability.[5] The psychopathically tainted becomes easily enthused, but the excite-

[4] Koch believes for example that powerful passions exhibited by prospective parents during the love act can create psychopathic inferiority in the offspring. This opinion was quite common at the end of the 19th century, related as it was to the ignorance which was still the rule regarding genetics. However, the notion was used as an excuse for what is now considered rather oppresive moralizing. In popular scientific writings people were warned of the diseases and defects that might strike their children-to-be if they did not live a reserved, sound and sober life. Cf. e.g. Krafft-Ebing 1885; Cullerre 1888; Angel Drake 1903.

[5] In this context Koch employs the expression *reizbare Schwäche* (irritable weakness), a much-used phrase among Germans, which according to him indicates "that the tainted are with uncommon ease strongly engaged by the most varying stimuli and impulses. That is to say, they are irritable, but the function thereby released has no real force, nor is it properly lasting. The nervous force of the tainted is rapidly drained and thus their irritability is allied to weakness" (Koch 1888, p. 39).

ment disappears as easily as it was generated. They will for example form strong attachments to some people, but after a short time the positive feelings cool or are even exchanged for the opposite emotions. The psychopathically tainted are impulsive, sometimes cruel, in some way paradoxical in their behavior. They love to draw attention to themselves, they fanticise and boast, are vain and proud. It is incomprehensible for the layman that such personality traits could be caused by an inferior brain; consequently they consider these individuals to be "sensitive, lazy, cruel, mischievious, incorrigible children" (ibid. p. 41).

In the third class, which Koch calls psychopathic degeneration, the above described traits are further magnified, and the affected individuals appear to the average man as unreliable, indeed, as scoundrels. They are often unable to entertain ethical ideas, hence their actions cannot be controlled by such. But observe that this is not in any real sense a question of moral insanity, for according to the author such can only be said to exist when psychopathic inferiority has drifted into a mental *disease* (notice the term "moral insanity", that is "moral mental *disease*").

Intellectual inferiority is also prevalent in the above group, though it is not as pronounced as moral shortcomings. Side by side with certain well-developed intellectual faculties these individuals show a notable superficiality, lack of clarity, sharpness and judgement and in many cases a failing memory.[6]

Koch's reasoning holds nothing original for those acquainted with Continental psychiatry of the later 19th century. It contains a recapitulation of central thoughts in the theory of degeneration, above all the polymorphic heredity, even if Koch himself claims to dissociate himself from Morel. Thus what he really does is to delimit and systematize the phenomena in the area between mental health and illness in a more distinctive fashion than had earlier authors. He then gives this widespread group a name which is new in the context. For initiated contemporary collegues, this was quite clear. Näcke (1896, p. 468) for example, points this out in a review of one of Koch's later works:

> All that is new is the nomenclature and the systematizing, which we cannot in fact be certain could actually be carried out, for we seldom have access to sufficiently detailed anamneses; and even if this was the case, subjectivity is always a possibility.*[7]

What happened, however, was that the term was soon taken up by a responsive audience.[8] It was obviously considered practical to have a collective term for a

[6] Cf. Näcke's discussion in section 4.3, above.

[7] From his side Koch (1891–93, pp. iv. f.) claims that he had done more than merely place a new name on an already delimited phenomenon. According to him this would not only be worthless but in fact wrong.

Koch had his doubts about the word *Minderwertigkeit* but was not able to find anything better. However, he does emphasize that the diagnosis psychopathic inferiority should not be communicated to the individual patient.

[8] It is worth noting the similarities between Koch's success with *die psychopathische Minderwertigkeiten* and Beard's with the neurasthenia concept. Neither had developed a basically new idea, but their terms gave names to conceptions that had only vaguely been defined; thus their rapid spread and character of psychiatric vogue. Cf. chap. 3, note 8, above.

category that was certainly diffuse, but which had long been considered discernible. In his monograph on the psychopathic inferiorities (1891–93) Koch lists a few of the expressions which preceeded his *psychopathische Minderwertigkeiten*: hereditary temperament, hereditary neurosis, neurasthenia, nervous constitution and neuropathic constitution. As he rightly points out, these terms were not sufficiently precise, nor were they a part of any unified system. This is something he would rectify.

What then are those conditions Koch wanted to place in the group *psychopatische Minderwertigkeiten*? We have already mentioned the *reizbare-Schwäche* syndrome (cf. note 5), which is closely related to the concept of neurasthenia. We have also indicated character traits which later authors ascribed to the hysteroid personality, e.g. histrionic behavior and egocentricity.

Koch includes various types of compulsive symptoms. Sometimes it is a case of compulsive impulses alien to the personality and situation, sometimes more specific obsessions such as "always thinking the opposite", *Grübelsucht, folie à doute, Platzangst* (agoraphobia), etc. It is clear then that today many of Koch's psychopathic conditions would be termed neuroses.

He also includes the defectively healed psychoses to be among the psychopathic inferiorities. This group is commonly considered to belong to mental illnesses, but according to the author this is incorrect; it is a question of an arrested disease process, and therefore these states are acquired psychopathic inferiorities.

Finally, Koch considers the more serious intellectual disturbances, which often occur in combination with physical defects, to fall into this category. The physical anomalies are for him obvious so-called *stigmata degenerationis*.

Koch claims that there is no real cure for the psychopathic conditions, but physicians must of course see that the affected patients are not exposed to too great a stress. Diversions, cold baths, etc. are recommended. A good effect is also achieved by the doctor's calm assurance that they do not suffer from mental illness, a subject about which they are often anxious.

5.1.2 Ziehen: Psychopathic Constitution

Ziehen further developed Koch's concept, but preferred to speak of psychopathic constitution. It is significant that he largely neglects Koch's work. Clearly he does not consider the latter's contribution as anything new, and indeed, essentially it was not.[9]

Ziehen gives the concept of psychopathy greater practical application in part through relating it to various types of behavioral disturbances in children. Thus he

[9] Judging from the foreword of Stelzner's treatise (see below), she seems to have worked closely with Ziehen, so that her idea of his contribution regarding the concept of psychopathy should be close to Ziehen's own. She claims Ziehen's priority in this field.

makes it relevant for educators and psychologists. In the third part of *Geisteskrankheiten des Kindesalters* (1902, 1904, 1906) he treats *Die psychopatischen Konstitutionen*. According to him the psychopathic constitution is, next to congenital feeble-mindedness, the most common and important of the mental disorders of childhood. Psychopathic constitutions are unlike the fully developed psychoses in that they often demonstrate mild, though varied, symptoms of mental illness. They only occasionally and, more importantly, transiently lead to more severe disease symptoms (see Ziehen 1906, p. 23).

Thus he does not follow Koch placing significance of the psychopathic constitutions being stationary conditions of abnormality. On the contrary, he expressly calls them disease conditions. Despite this, there does not seem to be an especially large difference between his view and that of Koch; for at the same time he emphasizes that the condition is most often inherited and chronic, and like Koch subscribes to the view of psychopathies as a boarderline condition between mental health and disease (cf. also Ziehen 1905, pp. 279 ff.).

The author's division of psychopathic constitutions is more reality-oriented than that of Koch, and unlike his it was actually used. The division can be made, he states, on symptomatic as well as etiological principles. Here he develops a rather picturesque image writing that in regard to the classifications of mental illnesses—as well as in the case of organic illnesses—it is not possible to avoid a kind of "double bookkeeping", one built on symptom and course, another on etiology. From the first point of view he considers the psychopathic constitutions to form a unitary group, from the other they do not (see Ziehen 1912, p. 132 f.).

In his volume of 1906 he primarily follows the symptomatic principle and treats the following psychopathic constitutions:

1) the general degenerative psychopathic constitution
2) the hysterical psychopathic constitution
3) the neurasthenic psychopathic constitution
4) the choreatic psychopathic constitution
5) the epileptic psychopathic constitution
6) the traumatic psychopathic constitution
7) the toxic psychopathic constitution
8) the residuary psychopathic constitution
9) the depressive psychopathic constitution
10) the hyperthymic psychopathic constitution
11) the paranoid psychopathic constitution
12) the obsessive psychopathic constitution.*

The first group, the general degenerative psychopathic constitution, is a formal exception from the symptomatic principle of division. But Ziehen is still of the opinion that there exists "a psychopathic constitution, preferably on the basis of hereditary degeneration, which is possible to delimit rather sharply" (ibid. p. 24). Through its characteristic mixed symptomatology (described by many other

authors) this group stands out as a separate one. What he means here is the syndrome of minor signs of mental degeneration which especially the French since Morel described in depth (sensitivity, irritability, volatility, tics etc.). He himself compares this group to Magnan's mildest degree of *folies héréditaires*, commonly termed *dégénérés supérieurs* or *déséquilibrés* (cf. section 3.2.3, above). Often this hereditary taint is accompanied by physical so-called *stigmata degenerationis*, but it is Ziehen's opinion that only numerous occurrences of such stigmata can be of diagnostic value.

No intellectual defect occurs in uncomplicated, hereditary psychopathic constitution. But according to the author it is not uncommon to find mild intellectual deficiency in psychopathy, which of course complicates the diagnosis (cf. also Ziehen 1912, p. 136).

Most of Ziehen's other psychopathy groups are also considered to be hereditarily determined. The hysteric psychopathic constitution is for example often hereditary, but may in certain cases arise because of earlier illnesses and improper upbringing. The neurasthenic psychopathic constitution can be the result of inherited weakness of the nervous system but might also be caused by metabolic disturbances, anemia, need of sleep, masturbation or psychic overexertion from e.g. too much school work.

Also the depressive and hyperthymic psychopathic constitutions are commonly hereditary. The depressive constitution is according to Ziehen equivalent to Kraepelin's *konstitutionelle Melancholie* or *konstitutionelle Verstimmung*, while the hyperthymic variant corresponds to his concept of *konstitutionelle Erregung*. This group is commonly called *unverbesserlich leichtsinnig* (incorrigibly rash) by the general public.

After his coverage of the different psychopathic groups Ziehen emphasizes that the list could be extended considerably: "Nearly every case offers a new variation or combination of the symptoms here described" (Ziehen 1906, p. 106).* The entire area is diffuse and difficult to define, and he therefore reaches the following conclusion "that all these psychopathic constitutions make up *one single*, large family of diseases" (p. 106).*[10]

Helenefriderike Stelzner drew on the psychopathy doctrine of her teacher, Ziehen, in writing her work *Die psychopathischen Konstitutionen und ihre sociologische Bedeutung* (1911). This is a broad review of a number of disturbed children whom the author considers to suffer from psychopathic constitutions. The views of the author on psychopathy[11] reflect in all probability those of Ziehen (cf. note 9), and the work has of course contributed to the dissemination of his ideas.

[10] We have here an example of how much of the theory of polymorphic heredity that still controls Ziehen's thought as late as 1906.

[11] The author herself uses the expressions psychopathy and psychopathic constitution alternatively.

Stelzner characterizes once again psychopathy as a border area between mental health and illness, and she considers the concept psychopathic constitution to be very comprehensive. Koch's *psychopathische Minderwertigkeiten*, Kahlbaums *heboidophrenie*, Weigandt's *leicht abnorme Kinder*, the *dégénéré supérieur* of the French, the teachers' so-called tired child—all are encompassed by psychopathic constitution. According to her the other concepts are actually superfluous (Stelzner 1911, p. 4).

Also Stelzner strongly emphasizes the importance of heredity in psychopathy. She points out that "heredity is already to be found in the word constitution" (ibid. p. 13).* At the same time she gives a quite good description of the extremely traumatic environments from which her clientele came—most of them from the lower levels of society—and her faith in the possibilities of making socially useful citizens of these children through another sort of upbringing is less pessimistic than the opinions one encounters in other contemporary psychiatric authors.

5.1.3 Kraepelin: Psychopathic Personality

In the different editions of Kraepelinian psychiatric textbooks (cf. section 3.2.4, above) one can follow the development of the psychopathy concept. The expression *die psychopathischen Zustände* (the psychopathic states) appears in the fifth edition, 1896. Under this heading the author treats *Entartungsirresein*, (insanity of degeneration), neurasthenia, anankastic states, impulsive insanity and homosexuality.

In the sixth edition, 1899, the heading *die psychopathischen Zustände* has got the addition *Entartungsirresein*. With this Kraepelin will probably emphasize that he considers the whole group to belong to the degenerative family, that is to say, to take its origin from the polymorphic heredity. This manifests itself in "a permanent morbid transformation of the essential stimuli of life (*Lebensreize*)" (Kraepelin 1899, p. 529).*

A distinction important for the continued development of the German psychopathy concept was introduced in the seventh edition (1904). Kraepelin now finds it useful to distinguish between more pronounced psychopathic conditions which have the character of a disease course and those of a more stationary nature which can be considered personality defects similar to disturbances in intellectual development.[12] This distinction was not, as we have seen (see section 4.3, above), totally new. In the third edition of his textbook Kraepelin had for that matter placed moral insanity under the category *psychische Entwicklungsanomalien* (mental retardations). What Kraepelin is actually doing here is making more clear

[12] Kraepelin's disciple Schneider (cf. section 5.2.2, below) writes about this division (1958, pp. 1 f.): "He (Kraepelin) has thereby laid the foundation of the theory of psychopathic personalities. The blueprint was complete already at this point".*

some differences, which were to be of fundamental importance during the years to come.

Thus by way of summary we have the following three conditions: psychopathies with the nature of a disease; stationary psychopathic conditions seen as developmental disturbances; and intellectual retardations. The first group which the author had earlier called *die psychopathischen Zustände*, was from 1904 *die originären Krankheitszustände* (original disease states). The other group was given the new rubric *die psychopathischen Persönlichkeiten*, an expression which has come to be one of the most used designations in discussion on psychopathy (cf. appendix).

Regarding psychopathic personalities the author writes that he considers it wise to focus attention on the primary forms, those of greatest importance for the psychiatrist, while "the continued development of this wide and promising area will be a task for future research" (1904, p. 816).*[13]

The following are the psychopathic categories treated:

1) The born criminals
2) The unstables (*die Haltlosen*)
3) The morbid liars and swindlers
4) The pseudo-querulants.

There is little to add to what has been said earlier about the born criminal (see above, chap. 4). Characteristic of the second group, the unstable, is their markedly weak will. There is little wrong with their intelligence, but they almost completely lack the drive to carry out conscientions and enduring work. They often begin with great enthusiasm but soon tire and thus have great difficulty in concluding for example their education as planned. According to Kraepelin, many habitual criminals suffer from this psychopathic disorder, especially prostitutes, beggars and vagabonds.

The group "morbid liers and schwindlers" was earlier described by Delbrück under the heading *Pseudologia phantastica* (cf. section 4.3, above). These people seem gifted when viewed superficially, and undeniably they are possessed of certain talents. They rapidly comprehend a situation, adapt with marked ease, absorb a great many facts, poems, citations, etc. which they regurgitate with great skill. But since they also are possessed of a distinct desire to imaginatively improve upon reality, all they say and do ends in a hopeless mixture of fact and fancy. On this tendency to romance Kraepelin writes that the ill are aware of their confabulation, "but they are carried away by their material, weaving tales much in the

[13] What Schneider actually claims (1958, pp. 1 f.) is that Kraepelin "with the expression *psychopathischen Persönlichkeiten* only aims at more or less *disturbing* forms, and thereby he approaches the 'inferiorities' once again".* Thus he considers that Kraepelin contributed to the deterioration of the psychopathy concept through his choice of psychopath groups. Cf. sections 5.2.2 and 5.2.3, below.

manner of a poet, without making their inclination clear to themselves" (ibid. p. 833).* Afterwards their earlier statements force them to continue, but even without this external motivation they are not capable of resisting that inner temptation.

Kraepelin writes that he had already pointed out, in his description of querulous paranoia (*Querulantenwahn*), that there is a group of morbidly predisposed personalities whose eccentricities are similar to the symptoms of genuine querulous paranoia, but without the occurrence of clear delusions (ibid. p. 836). Hence he refers to them somewhat inappropriately as pseudo-querulants. They often have average or above average intellectual gifts. Their memory is also good, but consequently colored by the particular suspicions and motives that control them. Therefore conditions and other people are often perceived distortedly and are wrongly judged. Thus on the one hand pseudo-querulant personalities are suspicious, stubborn and very difficult to convince. However, on the other hand they uncritically accept anything that superficially agrees with their own opinion. They most often have a well developed self-esteem and in their own eyes their private interests easily grow to a significance as if they were basic human necessities.

The eighth edition of Kraepelin's text, which was published in 1909—15, did not show anything principally new as regards psychopathic personalities. Once again the author points out the tradition in this field to distinguish between intellectual retardation and deficiencies of the emotions and will. The latter are now generally called psychopathies (1915, p. 1781).

Kraepelin also sees hysteria, paranoia and the preliminary stages of manic-depressive disease as psychopathies in the widest sense of the term. Additionally he asks himself whether there might not be reason to speak of an epileptoid psychopathy, indeed, even a variant related to schizophrenic disorders (ibid. pp. 1974 f.).[14] But he still finds it useful to maintain his division of psychopathic conditions into *originäre Krankheitszustände* and *psychopathische Persönlichkeiten*. According to what he writes it was difficult for him to reach a satisfactory grouping of the latter, for he has found a rich variety of ill and healthy characteristics in each psychopath. However, he considers that seven psychopath groups have special psychiatric relevance. The most markedly psychopathic trait in each instance gives the group its name. Other distinguishable categories as for example *die Wirrköpfe, die Aestheten, die Schwärmer und Fanatiker* etc. he passes over.

Four of these seven groups have been treated earlier, but a few of them have changed name. The expressions "the born criminal" and "the pseudo-querulants" disappear in favor of the terms *die Gesellschaftsfeinden* or *die Antisozialen* and *die Streitsüchtigen* (the quarrelsome). The three new groups are *die Erregbaren* (the excitable), *die Triebmenschen* (the impulsive), and *die Verschrobenen* (the eccentric).

[14] Cf. those views later advocated by Kretschmer (section 5.2.1, below).

Characteristic of the excitable is their great emotionality which results in their being driven into various affective states for insignificant reasons. Normally they must be treated with care to keep them from becoming furious and committing rash acts. Similarly, they sink easily into dispair and then attempt suicide. They can be quite dramatic in these episodes, writing tear-soaked farewell letters, etc. However, they pull out of the depression just as quickly and look back on their emotional actions as being foolish. Of course many of this type of psychopath break the law while in their empassioned state, usually committing crimes of violence.

Under the heading *die Triebmenschen* (the impulsive) Kraepelin gathers a group of psychopathic personalities that are connected with "impulsive insanity". This is a question of individuals exhibiting impulsiveness or compulsion in their actions which are not, however, as incomprehensible or alien in regard to the habitual personality as with impulsive insanity.

Kraepelin distinguishes three subgroups in this category: *die Verschwender* (the spendthrifts), *die Wanderer* (the vagabonds) and the dipsomaniacs. The so-called spendthrift is unable to adjust his life style to his income. He will live in lavish style, acquiring a fine flat, race horses, spends much on motor cars, all with no thought of the costs. Many of these become gamblers, travelling for example to Monte Carlo, while others devote themselves to debauchery, keeping expensive mistresses. In this manner great fortunes can dissolve in a few years, debts grow and the temptation to commit an economic crime increases correspondingly.

The vagabond's need to travel can arise out of a depressed condition, weariness with daily life, inner tension, sometimes in combination with sudden acquisition of a large sum of money. As soon as the desire arises it is acted on. They simply disappear from their homes, wandering for weeks and months, managing to survive with temporary jobs, stealing, sleeping in haystacks, assuming false names, etc.

Dipsomaniacs or periodic drinkers can be socially valuable individuals who care for their work and family during their abstemious periods. When they enter a phase they are often irritable and suddenly aggressive, cannot stand themselves, become fed up with everything but at the same time feel an implacable lust to pull themselves out of this state with the aid of alcohol. When they finally give in to this urge they devote themselves to a reckless drinking that they themselves are totally unable to control.

Regarding the group "the eccentric" Kraepelin notes that they are characterized by a lack of uniformity or consistancy in their mental lives. They are often disorganized, forgetful, underachievers, without necessarily being untalented: "The brain is now and then striking" (ibid. p. 2039). They are given to exaggerate and show a taste for eccentric and otherworldly ideas. They are often quick-witted, writing long and pompously formulated articles. Believing that they are intended for greater things, they of course easily feel passed over. The author states by way of conclusion that there are many distorted personalities, most of which must, however, be considered as preliminary stages to or residual con-

ditions after dementia praecox, so he does not consider such states to be among the psychopathic personalities.

5.1.4 Some Other Contributions

Karl Birnbaum (b. 1878) was one of the first to take up Kraepelin's expression psychopathic personality. In *Über psychopathische Persönlichkeiten* (1909) he attempts a closer delimitation of this group. He starts with the concept of personality, which he defines as the pronounced psychic individuality (*Eigenart*) of a person (ibid. pp. 1, 8). In this sense of the term, personality has been almost eradicated in some of the mentally ill, while in others it is so implicated in the disease that it is possible to speak of a personality illness. So for example is the case with Kraepelin's category "paranoia".

In Birnbaum's view a similar position is motivated in regard to the psychopathic personalities. These cannot be fully understood without an analysis of their personality: "Personality type and illness type will here coincide, will be identical" (ibid. p. 4).*

The different psychopathic personalities are related in that "with them, an important mental factor is pathologically constituted" (ibid. p. 4). What does this common factor consist of? Here the author falls back on certain components of the degeneration theory. According to him psychopathic personalities exhibit the mental and sometimes even physical *stigmata degenerationis*, as described earlier (cf. section 3.2.2). These can be traced back to "disturbances of the germ matter and its development. This depends in turn primarily if not completely on hereditary taint, that is to say, hereditary morbid states in the begettors" (ibid. p. 5).*

In summary, the psychopathic personalities are presented "as individuals with an originally abnormal personality, as constitutional psychopaths" (ibid., p. 5).* Thus the primary criterion for Birnbaum is the abnormal predisposition. Hence psychopathological conditions showing similar symptom pictures as the psychopathic personalities but not similarly based on an abnormal predisposition shall not be called a psychopathic personality.

This etiologic stipulation for the denomination rapidly came to dominate in German psychiatry. Certainly psychiatrists noted some of the difficulties in determining whether or not a personality abnormality was based on a hereditary predisposition but the task was not considered to be impossible. Only since the psychodynamic schools have been able to show in a convincing manner the significance of the experiences of early childhood for personality development, the traditional German psychiatry has gradually begun to doubt the practical value of Birnbaum's criterion (cf. section 5.2.3, below).

In his main work, *Die psychopathischen Verbrecher* (1914), Birnbaum further develops his views on psychopathic personalities and examines the ways in which the abnormal predisposition might lead to criminality. In his opinion the psycho-

pathic personalities have considerable forensic significance, since their characterological abnormalities dispose to transgressions of the law. Unlike the mentally ill, they ordinarily live in freedom in the midst of society. Even their situation in criminal law is examined closely by the author.

Birnbaum's importance for the shape of the psychopathy concept can be summarized with the following points:

1) His work established the expression *psychopathische Persönlichkeiten* at the cost of other contemporary terms. This denomination as well as the word psychopathy subsequently became almost universally prevalent within traditional German psychiatry.

2) His predisposition criterion won great acceptance, as pointed out above. However, it gradually led to an intensive debate on the relative significance of heredity versus environment for psychopathy and neurosis (cf. section 5.2.3, below).

3) Birnbaum's concentration on the tendency of the psychopathic personality towards criminality contributed to the asocial and degrading tone which the expressions psychopathic personality and psychopathy soon acquired among the less initiated. Kraepelin's psychopath groups, behind which lay a basically social criterion, also contributed to this trend. In diagnosing for example antisocial or unstable psychopaths the degree of asociality and criminality was of course of decisive importance (cf. section 5.1.3, above).

It would seem that the 1910s were a period in which many German psychiatrists attempted to delimit a concept of psychopathy, to make it more precise both for themselves and others. In any event a considerable number of contributions to this end were published. In addition to those already treated we shall further touch on two authors, partly because they wished to place intellectual deficiency under psychopathy.

Karl Wilmanns (b. 1873) used the term psychopathy to indicate a specific type of degeneration; he considered degeneration to encompass "all morbid deviations from the normal", while psychopathy indicates "degenerations of the mental sphere" (Wilmanns 1914, p. 513).* Thus according to him psychopathy is equivalent to "degenerative states of mind" (ibid.).* As such it is congenital, but not always hereditarily based. It can occur through an unfavorable "germ mixture" (*Keimmischung*), through pre-natal injury caused by poisons in the mother's body, etc. Wilmanns does not set a sharp boundary between the normal and the psychopathic, considering rather that "there is an infinite variety of individual shades leading from degeneration through irregularity to the normal, equivalent to the relationship between variety and stem form" (ibid. p. 513 f.).*

As mentioned above Wilmanns also includes intellectual deficiency in his concept of psychopathy. Though it had begun to be accepted practise at that time to distinguish between intellectual and affective-conative abnormalities (cf. section 5.1.3, above), the author does not motivate his special approach to the subject. However, considering how clearly his article reflects a dependency on French

thought, especially that of Magnan (cf. section 3.2.3, above), it is not surprising that, like the French, he wishes to handle intellectual retardations among the degenerative states.

Hans W. Gruhle (1880–1958)[15] also incorporated defects of intelligence in psychopathy, or—as he prefers to say—the abnormal or psychopathic personalities. Nor does he motivate his approach. But the case should not be the same as with Wilmanns, since Gruhle is less influenced by the doctrine of degeneration. Rather Gruhle considers that congenital anomaly in the intellectual area is just as much a personality deviation as are emotional and conative abnormalities. Logically then intellectual disorders should be placed in the same category as the latter, that is to say, they should be considered personality abnormalities or psychopathy.[16]

Like Kraepelin and Birnbaum, Gruhle draws a clear line between psychopathic and psychotic. From a theoretical viewpoint "psychopathic" is for him a representation of a predisposition; the equivalent concept in biology would be variety. From a practical viewpoint "psychopathy" is a deviation from the average, from a definite frequent type of relevant age and sex (see Gruhle 1918, p. 71).

Unlike "psychopathic", "psychotic" signifies that something new takes place. Admittedly psychopathic predispositions can develop or regress, depending of environmental factors, but "they never turn into a disease process, depending solely on inner laws" (ibid. p. 71). Obviously this does not exclude the possibility of a psychopath being the victim of psychoses, but in principle these phenomena have no more association with each other than diabetes and congenital physical weakness.

That last statement is an interesting and principally important assertion, since it is notably distinct from the thinking of degeneration theorists, and also from the view later maintained by the famed Kretschmer (cf. section 5.2.1, below). They did not see any boundary between psychosis and psychopathy besides a purely conventional one.

Gruhle also touches on the question of the pejorative tone of the word psychopathy, not less relevant today (cf. chap. 1). He writes (ibid. p. 71):

> It has become apparent that many traits are socially repugnant, leading to a variety of difficulties in day to day life, bringing about conflicts, etc., and so one has become accustomed to considering psychopathic as something inferior.*

This seems completely wrong to him. The objective concepts in true natural science should not be mixed with social value judgements.[17] Additionally such

[15] Regarding the life and accomplishments of this distinguished German psychiatrist see Kolle (1963).

[16] Gruhle later abandoned this viewpoint because he was rather alone in taking it (see Schneider 1946, p. 5).

[17] Despite this expressed opinion Gruhle obviously sees nothing degrading in the label *geborene Prostituierte* (born prostitutes), the name of one of his psychopath groups (cf. Gruhle 1918).

deviations from the normal as enrich cultural life of a society are as much psychopathies as are the socially injurious. As we have seen above, Gruhle considers the expressions abnormal and psychopathic personality to be equivalent; hence it follows that the genius too is a kind of psychopathic personality. This reasoning should be compared with that later put forth by Schneider (see section 5.2.2, below).

5.2 The German Concepts of Psychopathy from the 1920s to the Present

5.2.1 Kretschmer's View of Psychopathy

In the mind of the common people the devil is thin with a sparse goatee on his narrow jaw, whilst fat devils seem rather good-natured and foolish. Intriguers are hunch-backed and cough a bit. An old witch must have a hollow cheeked, hook-nosed face. Where there is amusement, we find the fat knight Falstaff with red nose and shining bald head. The woman of the people, possessed of solid common sense is short and round and stands with her hands at her hips. The saint is tall and slim with slim limbs, transparent and pale. In short, virtue and the devil have a pointed nose, but fun has one which is short and thick.*

Thus Kretschmer (1926, p. 9)[18] introduced his now classic book *Körperbau und Charakter*, first published in 1921. He continues:

It is possible that phenomena, which centuries of tradition have let crystallize in popular imagination are objective popular-psychological documents, the result of the observations of the masses, which are also something researchers might well examine.*

And that is what Kretschmer does. He attempts to establish a relationship between body type and personality, starting from the two major psychopathological symptom groups fixed by Kraepelin: the manic-depressive or circular and the schizoprhenic.[19]

[18] Ernst Kretschmer (1888–1964) early became a respected name within psychiatry and psychology. With his work on body build and character he was also known far outside professional circles. Just as it is now a part of a general education to know a bit about psychoanalytical theory, there was a time when Kretchmer's body and temperament types were common intellectual property. His hypotheses have certainly not withstood the competition from more recent psychological theories, but it is still customary to devote a few lines to this typology in modern psychology books.

Kretschmer was also prominent in other areas, and those articles and books he wrote all bear the stamp of his stylistic talent and graphic descriptions of human beings. His wide humanist interest is reflected among other places in his autobiographical *Gestalten und Gedanken* which was published in 1963, the year before the author passed away.

[19] Kretschmer later distinguished yet another temperament, the viscose or adhesive. This he related to the athletic body type. The viscose temperament is characterized by a calm and a certain insensitivity, but above all by tenacity. The viscose also has a tendency to work up to a rage which is worked off in explosive forms. In this tendency Kretschmer finds a certain if weak relationship with epilepsy.

According to Kretschmer his material has shown three main groups: the leptosomic, the athletic and the pyknic types.[20] They are found in men as well as women, but due to the more rounded form of the female they are more easily observed in men. Now, according to the author these three types have a characteristic distribution between the schizophrenic and circular groups of psychotic patients. He finds an overbalance of pyknic body types among the circular, while among schizophrenics there are primarily asthenics, athletics and dysplastics.

In researching the temperaments[21] associated with respective body types, Kretschmer begins as stated with the psychoses. He finds no clear boundary between normal and abnormal, well and ill—only a successive transition (ibid. pp. 209 f.):

When we take the step into the normal psychological area we make no spring in thought. On the contrary, if we follow the ties between body build and mental predisposition from the psychotic area step by step through all variants of a psychopathic personality and thereby distance ourselves increasingly from the serious mental illnesses which were the starting-point for our investigation, we suddenly find ourselves unexpectedly among healthy people, surrounded by nothing but recognizable faces.*

[20] Important in the leptosomic body type is the poor growth in mass along with unreduced growth in height. This is seen in all parts of the body: face, throat, trunk, extremities. The body type was earlier called the asthenic, but the associations of this word with powerlessness and illness were such that Kretchmer preferred the term leptosomic (fr. Gr. *leptós*, slender).

The pyknic is distinguished by an extreme development of the body cavities, i.e., the breast, abdomen and head. Additionally there is a tendency towards fat deposits in the abdominal region. The total impression is in pronounced cases very characteristic. There is a medium-sized, squat figure with a soft, broad face on a short, massive neck. The extremities are soft and rounded with hardly any muscle or bone outline.

With the masculine athletic type there is a powerful development of the skeleton, musculature and skin. The shoulders are broad, the thorax and abdomen firm with a tapering trunk. In women the type is of course less characteristic.

Along with the primary types Kretschmer also speaks of smaller groups which are summarized under the name dysplastic types. Here e.g. is found the eunuchoid type.

[21] In classical antiquity "temperament" (fr. Lat. *temperamentum*, mixture) was thought to be the mixture of the four body fluids, blood, yellow bile, black bile and phlegm. These body fluids are described in the Hippocratic writings, the proportions of each fluid in the mixture being considered to influence the health. Galen (131–201 A.D.) links the bodily juices with the singular psyche of each human being. With differing combinations of them he arrives at eight variations. The doctrine of temperaments lived on during the medieval period and, with modifications, survived into the 18th century. According to this doctrine, depending upon which fluid was considered to dominate, one had a sanguine, choleric, melancholy or phlegmatic temperament. See e.g. Sjöstrand (1943).

After they were considered apart from the classic notion of the four bodily fluids the temperaments continued to play an important role in psychology. As we know the old name lives on today in our vocabulary.

The meaning of concepts such as temperament, character and personality have been and are still shifting (cf. e.g. Carlsson 1948, pp. 71 ff.). Nevertheless it is perhaps surprising that Kretschmer chose the expression temperament. However, with it he wishes to show that—in accordance with the very old idea of a connection between bodily fluids and psyche—his typology is based on reaction tendencies deeply rooted in the somatic constitution. The concepts character and personality ordinarily imply more: the psychic individuality crystallized through environmental influences and one's own efforts.

That temperament type from which, according to Kretschmer, schizoprhenics are taken, he terms schizothymic. The transitional form between the well and ill, that is the schizophreniform psychopathy, he calls schizoid personality. Similarly those individuals among whom circular psychoses develop are termed cyclothymic and the transitional forms to the clear manifestations of the disease are cycloid psychopaths.[22]

Among the cyclothymic Kretschmer distinguishes such types as "the happy conversationalists", "the placid humorists", "the silent emotionalists", "the comfortable epicures" and the "energetic man of action". Characteristics notable for the cyclothymic temperament are then sociability, good humor, friendliness, heartiness, humor, liveliness, hot temper, but among many also a certain melancholy and fragility. The same characteristics apply for cycloid psychopaths, though to a more pronounced degree.

Unlike the cyclothymic and cycloid individuals, who are direct, open and spontaneous, the schizothymic and schizoid often have two sides, an outward and an inward. Schizoid psychopaths can for example be very brutal, bitingly ironic or extremely shy and withdrawn, while their inner life shows totally different qualities. It is possible to be acquainted with them for a decade without really getting to know them. Indeed, many schizoid individuals are similar to, as the author paints it, "roman villas which have closed their shutters to the sharp sunlight, while to the muted illumination of the interior colorful festivities are celebrated" (ibid. p. 159).*

It is more difficult to distinguish between well and ill within the schizoid group, between the characterologically extreme and the psychotic, than it is within the cycloids. What happens at the recurring attacks of schizophrenia is not a distinct change but a gradual transformation of the personality structure. After such an attack, in a number of cases a post-psychotic personality remains, in which schizoid traits are prominent. In other, more difficult cases the personality crumbles completely (schizophrenic dementia).

According to the author the following qualities are characteristic for the schizothymes and to even greater extent in the schizoids: lack of sociability, silence, withdrawal, seriousness, lack of humor, isolation, shyness, timorousness, sensitivity, nervousness, irritability, love of books and nature. With certain types there is also compliance, kindness and inertion.

With the schizoid it is possible to discern a continuous series from the oversensitive "extremely delicate shrinking violets (*Mimosanaturen*), made of nerves" (ibid. p. 164), to the cold, pertrified, almost lifeless types. A mixture of sensitivity and coolness in one and the same person is a characteristic of the schizoid. Even with the shrinking violets there is, Kretschmer notes, "an aristocratic chill and distance, an autistic restriction of sympathy" (ibid. p. 164).

[22] Regarding the viscose temperament (cf. note 19) Kretschmer later adopted an equivalent psychopathic personality type, the epileptoid.

Kretschmer's view of mental health and illness as a continuous phenomenon has a history which goes back at least to the degeneration theoreticians who, as we know, were speaking of different grades of degeneration without drawing any distinct borderline between them and pronounced mental illness. Thus we can trace a line of thought from these to Kretschmer via the degeneration theoreticians and thereafter, among others, Ziehen and Bleuler.[23]

The latter, Bleuler, had a pragmatic view of psychiatric classification (see E. Bleuler 1962, pp. 59 f.), which is also reflected in his view on psychopathy. He writes (ibid. p. 64):

One will hardly do without the word (psychopathy) but only as a designation for all such deviations from the norm that have not yet been described in the form of distinct disease pictures. Thus, the demarcation is negative and one cannot question whether a mentally singular individual is a psychopath or not. The real question to be asked is whether he can be referred to a distinct class of psychoses or other anomalies. If this is the case then he is designated as schizophrenic, hysteric, or something similar; if not, then it remains for us to give him the general label psychopath, which tells us nothing about the form of the deviation.*

But Bleuler's critical words do not seem to have much impressed his contemporary colleagues, dominated as they were by the German affection for divisions and subdivisions.

With Schneider (see below) we have another view both of the value of psychiatric "detail diagnosis" and of the border land between mental health and illness. His approach to the subject of psychopathy was to have a decisive significance for the developments to follow in the area.

[23] The Swiss professor of psychiatry Eugen Bleuler (1857–1939) is most known today as the originator of the diagnostic term schizophrenia. For many persons this was only a new name for Kraepelin's disease category dementia praecox. In recent years Kraepelin's school of psychiatry has been increasingly criticised, and in relation to this Bleuler has somewhat unfairly "taken his share". Far from being a mere echo of Kraepelin, he was for example one of the first psychiatrists in the German-speaking countries to show an interest in Freud's psychoanalysis, and he subsequently utilized certain of Freud's ideas in his attempt to understand and treat schizophrenic patients. Bleuler's magnum opus, *Dementia praecox oder Gruppe der Schizophrenien* (1911) which was the first delivered part of Aschaffenburg's *Handbuch der Psychiatrie*, cast much new light on this mysterious ailment.

It should be noted that he speaks of schizophrenias. He did not see schizoprhenia as a unitary disease entity but as a number of related ways of reacting to internal and external stimuli. Through his ability to empathize with the individual patient and gain glimpses into their closed world he discovered much that Kraepelin—despite his incomparable research efforts—was never to reach.

Psychiatry historians today see Bleuler as one of the great within his science in the decades after the turn of the century. Zilboorg (1957/58) compares him with Kraepelin and Freud. He was in many respects unlike those two: not greedy for honor as they were, nor was he primarily a researcher, but a clinician. His openess, humanity and anti-authoritarian stance made him a popular teacher. Such widely differing research personalities as C.G. Jung, André Repond, Karl Abraham, Abraham Brill, Ludwig Binswanger and Herman Rorschach were all positive towards him and developed under his guidance (see Krapf 1957/58). An observation by Freud illuminates the climate at Burghölzli, the mental hospital outside Zurich where Bleuler was in charge. He states that most of his followers and co-workers in this period came via Zurich. Regarding Bleuler and his psychiatry see—in addition to sources already named—Bleuler, M. (1955, 1962) and Kolle (1956).

5.2.2 Kurt Schneider's Theory of Psychopathy

Schneider's[24] *Die psychopathischen Persönlichkeiten*, subsequently widely distributed and influential, was originally published in 1923 as a modest section of Aschaffenburg's *Handbuch der Psychiatrie*. The ninth edition of the book was published in 1950.[25] In the space of 87 pages the author attempts to delineate the difficult subject of psychopathy which according to him will not allow itself to be described as a disease among other diseases, but rather makes up "an endless number of variations of human nature" (Schneider 1923, p. 5).*

His task forced Schneider to brusquely push aside many of the obstacles in his path. After an introductory theoretic discussion in which he concisely and in a short space defines his concepts, he presents a psychopath typology[26] which is intended above all to give classifying psychiatry a usable tool. Most probably this practical approach contributed to his success.[27] In fact his view on psychopathy

[24] Kurt Schneider (1887–1967), a student of Kraepelin, was primarily involved with clinical psychiatry but also had a great interest in theoretic psychopathology. His many conceptual distinctions influenced German psychiatry over a long period of time (cf. Mayer-Gross 1960, p. v). Schneider's radical view of psychiatric disease concepts also had consequences for his ideas on psychopathy. For him the disease concept was associated with somatic injury or process. Consequently it was only in those cases in which a pathological process or lesion could be demonstrated in the neurological substrata, or was at least strongly suspected, that one could rightly speak of a mental illness (cf. note 29, below).

Schneider was made professor of psychiatry and neurology in Cologne in 1922 and was later for many years professor in Heidelberg.

[25] "The influence of the 'Schneiderian' book at home as well as abroad can hardly be overestimated", writes Kallwass (1969, p. 4, note 9) and cites from the foreward to the ninth edition (1950, p. 3): "Many have learned from it and many authors have plagiarized it". I can confirm the truth of that statement. For his part Kranz (1959, p. 282) considers that Schneider's writings on psychopathic personalities can only be compared with Kretschmer's *Körperbau und Charakter* in the question of publicity and influence.

[26] Regarding the terms "type" and "typology" see chap. 7, note 14.

[27] Schneider calls his typology systemless. That means that his different psychopath types are not ordered as categories in a psychological theory of personality. Like Kraepelin, Schneider has only chosen a number of types characterized by some prominent individual personality trait, which also gives the type its name. The so-called systemlessness hardly means that he takes no position in the question of the nature and origin of psychopathy. He writes for example (1946, p. 12): "In our opinion the concept cogenital belongs to the concept of personality and to the nature of the abnormal (psychopathic) personality. 'Congenital' here is almost synonymous with predisposed (*Anlagemässig*)".*

Further on in the text (pp. 12 f.): "Regarding the abnormal (psychopathic) personalities it seems hardly likely to us that the exogenic plays an important role, even if acting as a contributing factor. There would seem to be no major objection to consider them as predominantly predisposed".*

Kretschmer and Kahn are among those who developed systematic theories of psychopathy. The latter, Eugen Kahn (b. 1887) worked out a typology which eventually caused a certain amount of confusion in the Anglo-Saxon psychopathy debate. His work *Die psychopathischen Persönlichkeiten* (1928) was translated into English within three years because he had been appointed professor of psychiatry at Yale University. However, the Americans did not understand his book. The constitutional perspective, the drive to classify and the broad content of the German psychopathic personality concept were obviously foreign to them. Thus we find an otherwise very knowledgeable individual such as Menninger coming to the following totally wrong conclusion (1941, p. 150): "Meyer wisely excluded the neurotic symptoms (from the psychopathic personality syndrome) - - - but twenty-five years later (1931) Kahn reintroduced them as forms of 'psychopathic personality' ".

and its classification would dominate Continental psychiatry for many years[28].

To a great extent Schneider follows Kraepelin. However, he attempts to maintain a scientific non-evaluative concept of psychopathy, and therefore rejects Kraepelin's socially valuing psychopath labels. In naming his own psychopath types he starts with characterological deviations, as he calls them.

It is possible, according to Schneider, to approach the problem of psychopathy in two ways: from psychopathology or from the psychology of the normal personality. Ziehen for example took the former route (cf. section 5.1.2, above), but Schneider considers the second approach to be the correct one. He reacts against the view that Kretschmer and Bleuler among others represent, that there is no real dividing line between psychopathy and psychosis, only a continuous scale. In this controversy he cites the distinction made by Jaspers between personality development and psychotic process,[29] which is one that should be maintained though it is sometimes difficult to discover.

Schneider begins, then, from *the normal*. What does this mean for him? By way of introduction he points out that there are two concepts of normality: the quantitative which means the same as "average", and the qualitative which is equivalent to "ideal".[30] For psychiatry as natural science the quantitative concept of normality is the only one utilizable. What normality means more exactly in regard to personality is, however, a question which the author declines to answer. The concept is for him only a pathfinding idea—"a zone of normality that is vaguely conceptualized but impossible to define exactly" (ibid. p. 13).*[31]

[28] This success was also due to the fact that he developed Kraepelin's system which was already well known and much utilized.

[29] Karl Jaspers (b. 1883) is known primarily for his existential philosophy. However, he began his professional life as a physician. In 1909, after achieving his medical doctor's degree he began work at the university psychiatric clinic in Heidelberg. There he wrote the important psychiatric work *Allgemeine Psychopathologie* (1913). It was later published in several revised editions. Jaspers's philosophical bent can be seen in his psychiatry. Even as a high school student he is said to have strived after a clarity in the question of what we actually know and do not know, and what the basis of our knowledge is. He applied these inquiries to psychiatric science which he found to be methodologically careless and marked by confusion (see Midgaard 1962; Kastberg Nielsen 1964).

Jaspers is careful to distinguish between personality development and process. Personality grows in his opinion out of predisposition in a continuous, natural fashion and in interaction with the environment. In opposition to such a development, which also characterizes psychopathic personalities, he sets the psychotic process. This is distinguished by "a lasting change of mental life. - - - These processes are entirely dependent on the cerebral processes" (ibid. p. 280).* Differential diagnosis, especially important in the case of milder schizophrenias, is the observation that there occurs a "break" (*Abknickung*) in the development.

As has been mentioned Schneider follows Jaspers in these questions. Thus he does not consider the transitional forms on the boarder between psychopathy and psychosis to have been clinically demonstrated, and he also prescribes, as pointed out in note 24 above, a concept of disease coupled to somatic dysfunction (cf. Schneider 1946, pp. 8 f., 47).

[30] Even Kant had, according to Schneider, pointed out these two meanings of the word normal (see Schneider 1923, p. 12).

[31] Möbius elucidated the concept of abnormality in a similar fashion in 1900. However, abnormal personalities were for him not only statistically abnormal but degenerated individuals.

Schneider moves from this concept of normality to the concept of abnormal personality. All of those personalities which are considered to lay beyond this indefinable normal zone, are abnormal according to him. We met the same definition of abnormal personality with Gruhle (cf. section 5.1.4, above). He placed an equivalency sign between "abnormal personality" and "psychopathic personality"; but Schneider, like Kraepelin (cf. section 5.1.3, above), considers it more useful to limit the concept psychopathic personality to those abnormal personalities with which a psychiatrist must deal. Thus he makes use of two concepts: one more comprising (abnormal personalities), and a narrower one (psychopathic personalities) which refers to a special group within the large category of abnormal personalities.

Schneider's much cited and discussed definition is as follows (ibid. p. 6):

> Psychopathic personalities are those abnormal personalities that suffer from their abnormality or whose abnormality cause society to suffer.*

Two groups occupy the center of attention here, those who need a doctor and the criminals. The author points out that Koch had already touched on them when he spoke of the psychopathically tainted, which were a nuisance only for themselves and those making trouble also for others. Of course it is impossible to strictly distinguish these groups, especially as an individual may belong to them both, that is, disturb as well as suffer.

When Schneider now separates certain individuals as psychopathic on the grounds of the suffering they incur for themselves and society—for that is how it works out, practically speaking—he risks abandonment of that value neutrality he found so important in respect to the concept of normality. He is aware of this danger, but in the first edition of his book he just calls for caution in the use of the psychopathy diagnosis. He recommends that one keep to the more general concept abnormal personality when engaged in scientific discussion.

In later editions the author gives a more detailed account of his view in this question; in the eighth edition (1946, pp. 4 f.) we find the following reasoning in respect to the society-disturbing psychopaths: it is unavoidable that social values play a role when one decides whether a certain individual is a psychopath or not. But this does not necessarily lead to any serious subjectivity since it is a question of selection made from an objectively defined group, namely abnormal personalities. He feels that the conditions are the same as if an expert on mushrooms was to write a book on poisonous mushrooms. The botanical concept mushroom has not become less objective thereby. So when Schneider speaks of psychopathic personalities he does so in what he considers to be a non-evaluative spirit since he falls back on the more general objectively defined concept abnormal personalities.

Much criticism has been directed at this kind of reasoning. For example Larsen (1977) recently touched on the problem. He starts off with the observation that, if our examination is a superficial one, it may well seem that Schneider did indeed retrieve his "objective" concept of psychopathy through his artifice. After this

courtesy Larsen goes on to say that the idea of an average norm is a vague quantity impossible to define exactly. Even though the average norm could be made more precise, this still does not help, for even then the judgement of sufficient deviation must be conditional. According to Larsen, the most pertinent grounds for Schneider for getting cought up in this involuted reasoning was his desire to establish that mental deviations can be assessed objectively which is impossible (see Larsen 1975, p. 51).

Schneider's ideas can also be criticised in another way. Even if it was possible for him to objectively establish the border between normality and abnormality, this does not mean a reduced subjectivity in the selection of psychopaths from the group of abnormal personalities. It is those suffering and disruptive personalities that are in the limelight, but how is it decided what is "suffering", and what is "distruptive"?[32]

Like Birnbaum (cf. section 5.1.4, above) Schneider considers psychopathy to be inherited.[33] Certainly in the individual case it can be difficult to distinguish between hereditary deviations and those which are early acquired, but in principle the latter are considered pseudo-psychopathies.

Schneider has to a certain extent changed his opinions during the course of the more recent discussion on the nature-nurture problem concerning psychopathy. However, he does this in such a way as to include more than merely the hereditary predisposed in the concept *Anlage*. What he means by that is obscure. In an article written in 1958 we read (Schneider 1958, p. 3):

> Personality has got something, begins with something, before its development. An entelechy is unfolded, there is a disposition, a potentiality to forming and realizing the personality. Thus there exists something by itself which is not caused by the experienced environment, but at very most formed by it. This "something" that we carry with us can basically not in any way be considered a hereditary predisposition.*

Let us now examine Schneider's ten so-called psychopath types. They are created on the basis of clinical views and thus are not derived from any characterological system—hence the expression Schneider's systemless classification of psychopathy (cf. note 27, above). According to the author such clinical descriptions have certain advantages such as fidelity to nature, lucidity and vitality. That which is clinically most notable is taken as the distinguishing trait of the type and also gives it its name. Schneider intends to avoid following Kraepelin's practise of applying socially degrading names. The type names should be psy-

[32] For me his method of approach, if I may employ Schneider's graphic mode of presentation, is like that of a man who, in as objective a manner as possible, separates all extremely short and tall individuals from the normal. Thereafter he sifts through this group of deviants judging which are beautiful and which are ugly. This final choice is hardly less subjective because it is undertaken within an objectively defined population.

[33] "As regards the genesis, we mean by psychopathic personalities—unlike Koch, Liepman and Ziehen—basically only congenital anomalies" (Schneider 1923, p. 19). Cf. note 27 above.

chologically descriptive rather than socially related. His attempt is not entirely successful which a glance at for example the subgroups to his "hyperthymic psychopaths" will show (see below). Schneider further points out that the type names are not suitable as diagnoses in individual cases, since this is a question of pure types which are seldom if ever found in reality. The names of the different subgroups can on the other hand be employed diagnostically.

1) *Hyperthymic Psychopaths*
The author borrows the term hyperthymic from Ziehen, who employed the expression *hyperthymische psychopathische Konstitution.* He finds "hyperthymic" more useful than Kraepelin's *konstitutionelle Erregung*, which allude to motor activity.

The group hyperthymic psychopaths is divided into a number of subgroups: quarrelsome hyperthymics, unstable hyperthymics etc. Characteristic for these people is an elevated mood. They are very active, but most often lack endurance in their activities and therefore constantly begin new projects. Many of Kretschmer's cycloid individuals are found here. According to Schneider the more harmonic variants of this type are, strictly speaking, not psychopaths, for they neither suffer nor do they pose difficulties for society.

2) *Depressive Psychopaths*
This group, characterised by predominantly depressive mood is divided into the subgroups: melancholy, despondent and paranoiac psychopaths (*schwermütige, missmütige, paranoische Psychopathen*).

3) *Insecure Psychopaths (selbstunsichere Psychopaths)*
This name comprehends a group of people characterized by inner uncertainty and feeling of insufficiency. Two groups are especially prominent, the sensitive and the anankastic.

With the sensitive the author means such cases as Kretschmer describes in his *Der sensitive Bezeihungswahn* (1918). These are people who place high demands on themselves and are extremely conscientious. They tend to shoulder the burden of the small failures and mistakes of everyday life, always inclined to blame themselves. They are also well groomed, have an orderly, "proper" way of life, and lack aggressiveness.

Schneider claims that German psychiatrists have worked with the category compulsive psychopaths since the beginning of the 19th century. Somewhat later they were dealt within the frame of the theory of monomania.[34] The French speak e.g. of *maladie du doute.* Griesinger was the first German to approach the

[34] A well-done historical survey of the treatment of the anankastic states in psychiatric literature of the 19th century is to be found in B. Gadelius' doctoral dissertation, *Om tvångstankar och dermed beslägtade fenomen* (On obsession and related phenomena), 1896.

problem scientifically. In 1868 in a lecture entitled *Über ein wenig bekannten psychopathischen Zustand* (cf. note 2, above) he describes among other things the compulsive need to constantly interrogate oneself.

4) *Fanatic Psychopaths*

This group is also divided into two subgroups: expansive fanatics and "soft" fanatics. Characteristic for all of them is the so-called prevailing ideas which control their actions. This is not necessarily a question of a peculiar idea per se; it is the manner in which the fanatic allows it to control and confine him that reveals his abnormality.

The expansive or aggressive fanatic is pronouncedly dynamic, filled with a single-minded fighting spirit and will to plunge into discussion with those holding differing opinions. However, it is never a question of real argumentation, since the outcome is clear beforehand. The fanatic never actually listens to anything except that which agrees with his own convictions; and these are at a fundamental level irrational, for they are based on purely subjective valuations. These individuals are sometimes not psychopaths in Schneider's sense (suffering or disturbing), but they can become so, as for example when the fanaticism expresses itself as querulance. Kraepelin's *streitsüchtige Psychopathen* is an example of this.

According to Schneider, "soft" or powerless fanatics are often found in religious sects. The Danish psychiatrist Reiter (1946) considers that one can well include those refusing military service, winter bathers, health food addicts, and anti-tobacconists in this group.

5) *Emotionally Unstable Psychopaths (stimmungslabile Psychopathen)*

This group is characterized by unexpectedly appearing and disappearing mood swings, especially depressive ones. On certain days it requires very little for these individuals to react with violent force; on other days they are less sensitive. The emotionally unstable build a special group, for they are distinguished by extremely rapid shifts in mood, as opposed to the depressive and hyperthymic psychopaths.

For many years there has been discussion of an epileptoid character, which is supposed to demonstrate personality traits, in many ways reminiscent of the emotionally unstable. Schneider, however, dissociates himself from the concept of epileptoid character, considering that there is no epileptoid psychopath, "at most a psychopath, suspected of being epileptic" (ibid. p. 65).*

6) *Self-Assertive Psychopaths (Geltungsbedürftige Psychopathen)*

Even Koch has written of certain psychopathically inferior persons "with a vain and conceited craving for conspicuousness" (cited in Schneider 1923, p. 69).* Such traits were early attributed to the so-called hysterical character. In his analysis of this personality Jaspers found in fact a common feature: "acting more superior than one is" (ibid.). Schneider also considered this to be central. However, he prefers to call the group self-assertive rather than hysterical, since

the latter term is so closely associated with physical, functional disorders. To further characterize the group he once again cites Jaspers (ibid. p. 69):

> Indeed the more theatrically they develop, the more these personalities lack any authentic emotional response; they are warped, no longer capable of maintaining a lasting emotional relationship, with no real depth, only yet another stage for counterfeiting and theatrical addictions—here you see the extreme developed hysterical personality.*

Schneider goes on to state that many described with Delbrück's diagnosis *Pseudologia phantastica* (cf. chap. 4, note 14, above) belong to the group self-assertive psychopaths. Of course Kraepelin's "liers and swindlers" (cf. section 5.1.3, above) also belong here. With such people the need to be noticed and admired has become perhaps the most important thing in life. Their longing to play a prominent role is so strong that reality and fabrication often flow together. "Herr Doktor", one of these patients once remarked, "I often don't know myself what is true" (ibid. p. 71).* Another expressed it thusly: "The comic or tragicomic in my fate lies in the constant battle between reality and fantasy" (p. 72).*

7) *Callous Psychopaths (Gemütlose Psychopathen)*

With callous psychopaths Schneider means that abnormal personality which "distinguishes itself primarily but not totally by an emotional dulness (*Stumpfheit*) vis-a-vis other human beings" (ibid. p. 75).* They build the very core of Kraepelin's psychopath group, the antisocial. But as previously mentioned Schneider dissociates himself from these terms. Closer to his own concept is F. Scholz's *moralische Anästhesie:* "the morally anesthetic is acquainted with moral laws, they are visible to him but he does not experience them emotionally and consequently he does not act in accordance with them" (cited in Schneider 1923, p. 75).*

It is clear that with his discussion of callous psychopaths Schneider comes very close to the old concept of moral insanity. He touches on this in passing, considering it to be completely obsolete. Nor does he think it is worth maintaining newer concepts such as *sittlicher Blödsinn* (ethical dementia) (Baer), *moralische Imbezillität* and *moralische Idiotie, moralische Oligophrenie* (Bleuler), *sittliche Farbenblindheit* (ethical colorblindness) (Liepmann) or *anethischer Symptomenkomplex* (Albrecht).

Schneider considers the question still open as to whether serious moral defects can exist without some demonstrable intellectual deficiency (cf. section 4.3, above). His own opinion is that callous individuals do exist in whom no intellectual defect in the ordinary meaning of the word can be said to exist. But it is unusual to meet highly gifted examples of this personality type. It is far more common that an emotional defect is combined with meager intellectual abilities.

Naturally emotional insensitivity in these individuals leads easily to their committing crimes. Not that all callous individuals become criminals, especially not those from higher social levels. Sometimes when occupying prominent positions such individuals reveal themselves as the sort of hard natures who would "step

over corpses" to achieve their goals. Kretschmer has very perceptively depicted them as a variant of the schizoid type.

8) *Weak-Willed Psychopaths (willenlose Psychopathen)*
The most prominent in this category is a slackness of will, more specifically, "a shallowness and lack of permanent motives" (ibid. p. 80).*

The group is largely equivalent to Kraepelin's *Haltlosen* (cf. section 5.1.3, above). Schneider considers them to be people without any powers of resistance, easy to seduce and unreliable; however, their susceptibility also means that they are receptive of positive influence, this showing itself in expresses of regret and resolutions. He describes them as "bending with the wind"; the most disparate inner and outer influences control them, nothing restrains (ibid. p. 80).* These individuals most frequently come in contact with the doctor because of alcoholism rather than criminality. Misuse of other poisons also occurs.

9) *Asthenic Psychopaths*
Many psychopaths show asthenic traits. One can then ask, writes Schneider, if it is necessary to establish a special asthenic psychopath type. In his opinion the medical experience does indeed point in that direction.

By "asthenic" Schneider refers especially to those people who are in conversation referred to as nervous. It is those sensitive creatures who cannot bear the sight of blood, who cannot take a sudden alarm, who withdraw quickly if anything unusual happens. They usually exhibit mild physical dysfunctions as well as insomnia, headache, fatique, heart troubles, etc. and often develop in the direction of hypochondriasis.

The asthenic psychopathy is closely related to the concept of neurasthenia (see chap. 3, note 8, above). However, the author feels that all talk of nerve weakness and attempts to explain the anomaly with neuro-physiological theories are all "mythology", and the term nervousness should be eliminated, at least from the language of physicians. Nor does he approve Aschaffenburg's *konstitutionelle Neurasthenie* or Bumke's *konstitutionell Nervösen*. Janet's term psychasthenia seems better to him, but through his theories it has been given a special content (cf. e.g. Sjövall 1967).

10) *Explosive Psychopaths*
Characteristic for the explosive is the violent affective outbreak for what seems to be insignificant cause. Their heedless fury sometimes has the nature of an attack and can obviously lead to serious crimes of violence. This way of reacting has been termed short-circuit reactions, for the persons concerned are usually good-tempered in other respects. Due to their special abnormality they must always be handled carefully. Kraepelin called his equivalent group *die Erregbaren* (cf. section 5 .1.3, above).

5.2.3 The Nature-Nurture Problem and Its Relationship to the Concepts of Psychopathy and Neurosis

As has been described earlier, during the second half of the 19th century psychiatry developed in the direction of the natural sciences, becoming increasingly somatically-oriented. Not least the theory of degeneration contributed to this, by placing heredity at the center of interest. During our own century the European psychiatry has continued to be distinguished by a basically somatic point of view, and it is only in recent years that new approaches have won more general reception.

Like many other psychopathological phenomena psychopathy has, as we have seen, been considered mainly hereditarily based. Of course the environment factor was not overlooked[35] but its importance was gravely underestimated. As Petrilowitsch (1960, pp. 22 ff.) rightly points out, this is understandable if one considers that traditional institutional psychiatry worked almost exclusively with adults. These have usually developed a well-structured, stable personality, which means that it is difficult to change. Ignorance as to the process of personality formation and its conditions, it seemed logical to see a manifestation of heredity in basic personality traits—including those which are abnormal.

The growing criminological research also seemed to confirm this idea. In 1929 Johannes Lange, a student of Kraepelin, published his famed research report *Verbrechen als Schicksal*. The title of the work (Crime as a destiny) reflects the author's point of view. In 1936 two new important contributions were published: *Lebensschicksale krimineller Zwillinge* by H. Kranz and *Die Ursprünge des Verbrechens* by F. Stumpfl.

These studies were methodologically far superior to the investigations of families earlier carried out within psychiatry and criminology. The so-called twin method was used here for the first time. This method starts from the fact that single-egg twins or monozygotes have identical hereditary factors, whereas the double-egg twins or the dizygotes are genetically as different as are ordinary siblings. Now, both Kranz and Stumpfl found a high concordance[36] of criminality between monozygotic twins, slightly more than 60 per cent. With dizygotic twins the concordance was as expected lower; in Kranz's material about 54 per cent and in Stumpfl's approx. 41 per cent. With Lange the differences were much

[35] Schneider (1958) points out that the concept of environment has changed considerably, in part because of psychoanalytic discoveries. With reference to the time when his own psychopathy theory originated, he writes (p. 3): "With environment one meant above all the social, the 'external environment': the criminal or alcoholic father, a loose mother, neglected living quarters, arresting for begging. What was new was the valuation of the 'internal environment' which is found functioning at a deeper level in the personality and is far more individual".* Cf. Kinberg (1940).

[36] The concept of concordance has been employed in twin investigations. Concordances are obtained by dividing the number of twins who are alike in respect to a certain behavior (e.g. criminality) by the total number of twins. The obtained quotient is then multiplied by one hundred.

greater; in his investigation the concordance for monozygotes was as high as 77 per cent, while that for two-egg twins was only 12.[37]

Sharp criticism was subsequently directed at these two German investigations. Psychoanalysts claimed that in important questions the researchers had accepted as presuppositions what they should in fact have proved. For example it had been assumed that twins who grow up together are subject to nearly identical environmental influences. One of the basic observations of psychoanalysis is that, on the contrary, each child has a unique interplay with his environment. This means that twins could grow up side by side in the same environment and still experience it differently.

Other critical views were also put forward. Additionally it has been pointed out that the criteria used in the selection of monozygotic twins were unsatisfactory. Another inadequacy was that in assessing the behavior of a certain individual, the researchers had been aware of his genetic relationship to the sibling twin. This could have led to biased interpretation of data. In similar investigations it is now required that the so-called double-blind method be employed. A further critical point of view comes from Stumpfl himself (1959, p. 2). He points out that the then-current human genetics was to a large extent confined to the sterile antithetical inquiry of heredity *or* environment, when it is actually always a question of interaction between the two factors.

Without further consideration an equivalency sign was set between "hereditarily determined" and "uninfluencable" or—as it was termed in the case of criminals or psychopaths—*unverbesserlich* (incorrigible). This led to a crippling therapeutic pessimism in regard to any anomaly which was considered to have an hereditary base.

In a lecture delivered in 1944 (first published in 1949/50) the psychoanalyst Schultz-Hencke attacks the basic view he finds permeates Schneider's theories of psychopathy.[38] According to Schultz-Hencke, he handles all these in a proper sense corrective measures rather unfairly. But this is to be expected, "for K. Schneider is on the whole convinced that psychopathy is a genotypical affair, hence finally *not* to be corrected" (ibid. p. 148).* However, we now know so much, he continues, that we must always place quotation marks around the word psychopathy.

[37] The above figures are taken from Rosenthal (1970, pp. 222 ff.).

[38] "The real attack from the psychoanalysts came only after the Second World War" writes Schneider (1958, p. 2). One is then prompted to ask why this attack came so late. An explanation may be that, during their more extreme first years, the psychodynamic schools were absorbed by their own inquiries and internal conflicts. Thus contact with the rest of the psychiatric and psychological world suffered. Another hypothesis which is not in conflict with this is that the ascension of the Nazis to power in Germany postponed an unavoidable confrontation between traditional psychiatry and psychoanalysis in the nature-nurture question. Most of the early psychoanalysts were Jews. Some of them emigrated during the 30s, others remained in Germany and as we know were silenced.

Schultz-Hencke emphasizes that in psychopathy "the peristatic conditions" (environmental factors) stand out as at least as important as "the genotypical". Unlike Schneider and those agreeing with him the psychoanalyst asks himself: "Is there anything to correct?" (ibid. p. 150). And Schultz-Hencke goes on (ibid.):

As soon as we become interested in changing of the psychopaths, the 'uncorrectable' plays a less important role, attention being focused on that which is possible to influence by the environment. - - - The theme of psychopathy must under no circumstances be discussed any longer in the fashion of K. Schneider.

In 1959 Stumpfl stated that he had learned much since the 1930s about the development of human psyche. Thus he can no longer accept Schneider's original definition of psychopathy. His belief is that at one time the theory of psychopathy filled an important function in asserting the difference between psychosis and personality abnormality. However, this role has been played out. That the theory of psychopathy is still employed in Continental psychiatry is due, according to Stumpfl—aside from practical conditions—to the unclear conceptual system of psychoanalysis. German psychiatrists with their feeling for systematics, find Schneider's concise and clear typology far more appealing than the "mythology" of the analytics.

Development of so-called psychopathy is according to Stumpfl basically the same as neurotic growth.[39] He also finds it rather seductive that one almost never hears of psychopathy in children, only of disturbed human relations. This is more easily explained in terms of neurosis.[40] Stumpfl thus concludes that in each individual case it is the attitude of the researcher that determines whether he shall speak of callous psychopath or schizoid neurosis structure, fanatic psychopath or a neurosis. He continues (1959, p. 2):

For the most part it seems to be so that a social disturbance or unsurmountable difficulties in therapeutic attempts leads to talk of psychopathy, though an unbiased investigation of such people would disclose the same conflicts as we are acquainted with from psychology of neurosis.*

In old age Schneider himself (1958, p. 58) is willing to abandon the concept so intimately linked to his name. However, this step does not mean to him the abandonment of a false idea but is rather the question of usefulness of nomenclature.

What he had attempted to accomplish in his youth was a socially and morally non-evaluative concept of psychopathy (cf. section 5.2.2, above). When this had failed for a variety of reasons,[41] and the concept degenerated until it could no

[39] This did not mean that Stumpfl completely passes over genetic factors in neurotic or psychopathic development. However, in his opinion the level at which human genetics currently finds itself makes it impossible to determine the relative role played by these factors in the context.

[40] A similar argument is put forward by the Swedish child psychiatrist Regnér in an article on the onset of certain psychopathies (1947).

[41] Schneider blames Koch and Kraepelin for setbacks in the attempt to achieve a non-evaluative psychopathy concept. He writes (1958, p. 2): "The inclusion of non-asocial forms could not in the long run, arrest the increasingly obvious drifting of the concept of psychopathy towards the social-

longer be employed in a meaningful way, he deems it proper that it disappear.

In a polemic against psychoanalysts Schneider definitely claims that he has considered neurotic development within the frame of his psychopathy theory. To a certain extent he is justified in this assertion. As early as 1927 he wrote on *die abnormen seelischen Reaktionen*, in which he includes e.g. certain conditions of anxiety and of depression. However, practically all of these reactions are in his opinion based on an abnormal personality (ibid. p. 10). "No neurosis without psychopathy" is a rather condensed summation of his opinion.

Schneider gives a more detailed treatment of neurotic reactions in *Klinische Psychopathologie* (1950), but the basic thought is the same as it was earlier. It is the abnormally strong reactions of the psychopathic personality to the stimuli of the environment that is the basis of warped development (*die abnorme erlebnisreaktive Entwicklung*). With the latter and similar expressions Schneider then attempts to encompass a number of those phenomena which psychoanalysts call neuroses. Schneider himself does not use the term neurosis, partly for reasons of etymology (cf. Schneider 1946, pp. iv f.).

In practice Schneider approaches the problem of psychopathy vs. neurosis in the following fashion: when the psychiatrist is confronted with the task of judging an individual, he attempts to estimate the proportion between the congenital and the *Erlebnisreaktive* or "neurotic" respectively. If he finds predisposition to dominate, he speaks of psychopathy. If on the other hand environmental factors predominate, he is dealing with a so-called neurosis. So it is the doctor's subjective decision as to which of these factors weigh most heavily in deciding whether a patient is to be called psychopathic or neurotic. This Schneider is willing to concede.

J.H. Schultz employs a similar line of reasoning as do Kranz (1959) and Binder (1960). Schultz (see Kranz 1959, p. 278) sees a continuous scale between hereditarily based psychopathy and milieu-related neurosis. In his opinion most cases are mixed forms, that is to say, the neurosis is secondary to a constitutional psychopathic state.

For Binder the genetic perspective is important, "for the manner in which an affection arises gives the best explanation regarding its inner state and comprises the firmest basis for prognostic and therapeutic conclusions" (1960, p. 181).* In addition to functional mental diseases,[42] which for Binder primarily comprehend

ly negative. Koch's 'inferiorities' and Kraepelin's limitation of 'psychopathic personalities' to refer to disturbing variations were constantly reiterated".*

[42] Like Jaspers and Schneider (cf. notes 24 and 29, above) Binder strictly distinguishes between abnormalities and diseases. He writes about the latter (Binder 1960, p. 181): "They are characterized by the appearance of the *qualitatively* different, what is for health completely alien deviations in certain functions or functional contexts. These deviations are original in the meaning that they cannot be traced back to quantitative disturbances".*

Binder continues (p. 181): "Through these (diseases) - - - a real break in the continual personality development occurs, with important mental relationships obviously frayed to pieces or disrupted".* On the other hand Binder does not consider that the disease concept in psychiatry should be reserved only for demonstrated or assumed organic morbid processes or injuries, for he also speaks of *functional* diseases.

schizophrenia and manic-depressive psychosis, he sets up functional abnormalities. Here it is only a question of quantitative changes in psychic activity and these changes he calls disintegrations (*Desintegrationen*).

Binder divides mental abnormalities according to the assumed importance of the heredity and environment factors. To the heredity-dominated disintegrations in the area of affection and impulse he gives the traditional name *Psychopathien*, while those which are primarily caused by environment are given the label *Psychogenien*. According to Binder they are often similar. He thinks it possible that a neurotic complex[43] may develop on psychopathic as well as "psychogenic" grounds. Only a thorough analysis of the personality and development of the affected individual will give the answer as to which kind of abnormality we are dealing with.

Important for differential diagnosis is the evaluation of the strength of the provoking environmental stimulus; if it is seen as ordinary, the strong reaction is considered to be primarily caused by a constitutionally vulnerable personality (psychopathic personality). On the other hand, if there is a serious environmental stress, then the basic personality of the individual should be of secondary etiological importance.

Binder finds it important to distinguish between these two conditions since prognosis and treatment are different in the two cases.[44] He disregards the expanded concept of neurosis, for in his opinion it does not consider the above mentioned relationships. "Neurosis" has through psychoanalysis come to mean "responsive to treatment", that is implying optimism. As Binder sees it this has led to an unfortunate "inflation" of the concept. Thus he sees no reason to abandon the concept of psychopathy in favor of such an expanded and uninformative neurosis category.

Instead of the old question "Genetically determined or caused by environment?" Petrilowitsch (1960) will, starting from his so-called structure psychology, set up a new and more productive antithesis: the well-structured and stable personality of the adult versus immediate environmental influences. Like the normal personality the psychopathic is for him "an amalgam of the inherited and the acquired" (ibid. p. 22).* He goes on to explain that, regarding *die Anlage*, which for him seems to denote approximately "constitution", the "inner" and "outer" are inseparably joined. Such habitual *Anlagen* determine the individual fates of the abnormal personalities. Due to the constant and recurring nature of

[43] Binder conceives of a limited neurosis concept. According to him a neurosis occurs only if an individual reacts to traumatic pressures in a contradictory fashion, in such a way that different parts of the personality respond in varying, unreconcilable ways. Thus an inner unsolvable conflict arises and is eventually incapsulated in the personality, building a so-called complex with a special autonomy and with powerful dynamics (cf. Binder 1960, p. 193).

[44] Cf. Stumpfl's view (note 39, above) as well as Kallwass's criticism (below) of the manner in which the differentiation between psychopathy and neurosis is often carried out.

certain traits, the observer is easily led to the premature conclusion that he is dealing with something hereditary (see ibid. pp. 22 ff.).

What then is Pertrilowitch's view of the concept of neurosis? Of course, operating from his idea of psychopathy he disapprove of the habit of calling all acquired personality disturbances neuroses. Before speaking of neuroses, a scrupulous analysis should, according to the author, be undertaken in an attempt to determine the individual's basic personality, that is, through a "structural reduction" determine the primary qualities (*die Primeigenschaften*) (ibid. p. 41). This "characterological" investigation is necessary for a proper evaluation, since that which appears to be neurotic is in fact often the expression of, or even the unavoidable result of an abnormal personality structure.[45]

For Kallwass (1969) it appears impossible to decide whether heredity or environment is the primary cause of an abnormal reaction or development. But the problem is, as this author sees it, of little practical significance. The common but empirically poor link between "psychopath" and "incorrigible" has in fact not had too much harmful consequences, due to the circular reasoning of which one is often guilty. Decisive in whether a certain case is considered to be a psychopath is such facts as all lead towards a pessimistic prognosis, e.g. frequent prison terms. Consequently when an individual is labeled a psychopath, that is, as hereditarily abnormal and incorrigible, it does not matter, for it was the "incorrigibility" which led to the diagnosis of psychopathy.

In concluding, Kallwass claims that the Germans have to choose between two ways. Either they must abandon their concept of psychopathy or they have to free it completely from its association with the nature-nurture problem.

5.2.4 Concept of Psychopathy in France

Remnants from the theory of degeneration, especially the hypothesis of a polymorphic heredity, were current in its land of origin, France, for a longer period than in the surrounding countries. This was partly the result of the great success Magnan had with his teachings (cf. section 3.2.3, above). However, even in France the concept of degeneration was gradually diluted until it signified no

[45] Schneider as well as Binder and Petrilowitsch criticise psychoanalysts for neglecting to consider basic personality in their neurosis theories, that is the hereditary based personality structure. This criticism seems to be partly misdirected. Those personalities that are termed character neurotics in psychoanalytic theory belong as far as I can see to that wide group that according to traditional German psychiatry is called psychopaths. And of course "character" means something deep-seated and stable in the individual (cf. chap. 6, note 36, below). The important difference between the two points of view would seem related rather to the opinion of the origin of this basic personality. The above named psychiatrists place primary emphasis on the inherited factors, while the psychoanalysts believe it is the experiences of early childhood which are decisive. Classical psychoanalysts made certainly a vague allowance for hereditary predispositions (see section 6.2.6, below), but this did not prevent them from believing neurotic personality types to be fixations of libidinal energy at certain levels of development (cf. e.g. Fenichel 1945b).

more than a hereditary mental taint, especially in the area of affections and will. Thus the expression *dégénération mentale* eventually fell into disuse. Magnan's *les déséquilibres psychiques* (states of mental unbalance) proved on the other hand to be a vital term for the problematic group in question, probably due to its expressive character. It is still used along with other terms.[46]

In 1912 one of Magnan's pupils, Ernest Dupré, presented a modification of Magnan's theories which came to be of great importance (see Dupré 1925; Baruk 1959, pp. 1240 f., 1967, p. 103). The degenerative states were now presented in accordance with contemporary German theories as heredity-based *constitutions psychopathique*. Dupré's ideas were developed by among others Delmas who described five such constitutional categories: *les constitutions perverses, hyperémotives, cycliques, paranoiaques* et *mythomaniaques*. Beneath the heading *constitution perverse*[47] were placed many cases earlier referred to the clinical group moral insanity. A monograph summarizing *le déséquilibre psychique* as the "constitutionalists" perceived it was published in 1947 by J. Borel.

For Sutter & Pascalis (1960) the concept *déséquilibre psychique* has considerable range and covers a greater number of phenomena than does Schneider's concept of psychopathy. They define their concept in this manner (ibid. p. 169):

> A permanent mental condition independent of any sort of psychotic attack, which manifests itself in the inability of the individual to commit himself to and follow a harmonic life style in accordance with his best interests, a life style adapted to the conditions in society.*

According to these authors *le déséquilibre psychique* is a significant predispositional factor in many cases of mental illness. In fact it indicates a defective and vulnerable psychic organization.

In the question of etiology Sutter & Pascalis take a modified position. They point out that the transfer of *déséquilibration mentale* from generation to generation, often to be seen, may just as well be a question of upbringing as of genetics.[48]

[46] The expression *personalité psychopathique* which derives from Kraepelin and Schneider has recently also begun to be used (see Ey et al. 1960, pp. 307 ff.). In this connection it should be noted that in France the term psychopathy has mainly kept its etymological significance (cf. note 2, above). Thus the term is not used for the group we have indicated, but rather one employs *états psychopathiques constitutionelles* or the just mentioned *personalités psychopathiques*. The same linguistic situation does not, however, seem to exist in Belgium (see Cassiers 1968) or in Switzerland (see Humbert 1947, p. 179).

[47] In the years after Dupré presented his constitution theory the term "perversion" became very popular in France with nearly the same connotation as the German *Abnormität*. More recently the term has been limited to comprehend *déviations antinaturelles*, but with that is meant not only sexual perversions but also—and perhaps primarily—antisocial behavior. Cf. Baruk 1959, pp. 1240 f.; Ey et al. 1960, pp. 309 ff.

[48] Of course the heredity-environment problem in regard to psychopathy and neurosis has been current in France as in other countries. For example, psychoanalysis early found prominent adherents here (such as A. Hesnard), who fought against the views of the constitutionalists. But this controversy does not seem to be in any way different than that in the German-speaking areas (cf. section 5.2.3, above); hence I have not penetrated it (cf. Cassiers 1968).

Pichot (1977) has in a survey of the psychopathy concept summarized the historical influences on the current French concept of *déséquilibre psychique* (p. 12):

French psychiatric works describe a special group of subjects under the terms of "Mental Unbalance" (déséquilibre mental) directly derived from Magnan. "Unbalance is the classical term used in France" states the Treatise on Psychiatry by Ey, Bernard and Brisset. The description has recourse to element of psychology and social behavior a particular stress being laid on the latter, in line with Dupré's views. The notion of fragility, directly derived from Morel and Magnan, and from the doctrine of mental degeneracy, remains fundamental. The only new shade of meaning concerns pathogenesis, where one no longer has recourse openly to degenerative heredity (as with Morel and Magnan) or constitution (as with Dupré) but where under the influence of psychogenetic trends influences of the environment are more readily assigned a role.

French psychiatrists and neurologists have, as we have seen (cf. chaps. 2, 3, 4), played an important role in the originating and development of the theory of degeneration. Thereby they also got an influence on the early German notions of psychopathy (cf. section 5.1, above). However, in our own century their efforts in the area have been more modest; their contribution has at least been of little international consequence.[49]

5.2.5 The Concept of Psychopathy in Scandinavia

The German notions on psychopathy got a footing with Swedish psychiatrists and criminologists during the first decade of the 20th century but did not come into more general use until the 1910s.[50] For a number of years the French influence had weakened in favor of German psychopathology. In 1908, when Kinberg[51]

[49] It has for example proven difficult to obtain in Sweden the French literature which I considered necessary for writing the present section (5.2.4).

[50] In *Allmänna Svenska Läkartidningen* (1909, pp. 930 ff.) one reads of mental illness (*sinnessjukdom*) and mental abnormality (*psykisk abnormitet*), the terms being defined in the following way (p. 937): "Mental illness in a strict sense is such a psychopathological condition as depends on a *continuous* disease process in the brain (e.g. dementia paralytica). Mental abnormality on the other hand is a psychopathological condition which is the manifestation of an abnormal brain state originating either in an unfavorable germ mixture and in this case hereditary (e.g. paranoid character) or as the result of a *past* disease process in the brain (e.g. imbecility, resulting from encephalitis in childhood)". Koch's concept of psychopathy is the first that comes to mind when reading these definitions.

[51] Olof Kinberg (1873–1960) for many years Sweden's most prominent criminologist, was among other things instructor in forensic psychiatry bearing the title Professor at the Karolinska Institute in Stockholm (1920–1939). He has been considered the founder of Swedish forensic psychiatry. Through his instruction and many publications he exercised a powerful influence in many areas of psychiatry, forensic psychiatry and criminology. He was also internationally recognized and in 1936 was recipient of the Italian Lombroso prize for his *Basic Problems of Criminology* (1935), which was a summary of several Swedish works.

Kinberg reacted early against the schematic fashion in which classic penal law considered human beings, and he shared completely the view on it hold by his older colleague Gadelius, that it was only "a fabric of concepts woven round the earlier, superficial knowledge of man" (Gadelius

treated abnormal criminality in his doctoral dissertation, *Brottslighet och sinnessjukdom* (Criminality and mental illness), he was demonstrably influenced by German authors. He uses the expression mental abnormality, while the term psychopathy still maintains its etymological significance for him. However, in 1917 the Swedish Psychiatric Association adopted a nomenclature which included the term psychopathic personality (see *Allm. sv. Läkartidn., 15,* 1918, pp. - 1132 f.).

In 1918 a criminological work by David Lund was published which was well done for its time. In his view on the psychopathy concept, he primarily followed Ziehen, but as psychologist and educator he was more inclined than him and other contemporary psychiatrists to ascribe decisive significance to environment concerning the etiology of asociality.

It was first in 1921—24 that a major psychiatric work appeared in Swedish, *Det mänskliga själslivet* (The human mind), in four volumes,[52] by Gadelius.[53] He thinks the psychopathies to be "the border territory between health and illness, from which - - - (mental illnesses) somehow derive, since this area contains the fertile soil where the disturbances, displacements and break-ups of the normal mental structure grow" (Gadelius 1924, p. 382).* This applies not only to the cyclothymic predisposition but also to "those manifestations of unapproachable reserve, hostility and shyness, of bizarre habits, crazy and twisted fancies that so often betray the catatonic[54] predisposition" (p. 382).* In this view of psychopathy we recognize survivals from the theory of degeneration as well as influence of Ziehen, Bleuler and Kretschmer. The fertile soil, which Gadelius speaks of, allude of course to the inherited "neuropathic" or "degenerated" state of mind.

1906a, p. 99).* Kinberg was interested in the criminal, not the crime, and he thought that measures should be taken against him commensurate with his singular characteristics.

Kinberg was an exponent of the Italian school of positive penal law, and for many years fought with great vigour the notion of freedom of will (cf. e.g. Kinberg 1917). He was also biologically oriented in his view of man and to a certain extent defended Lombroso's theory of *l'uomo delinquente* (cf. section 4.2, above) which in his opinion was not completely without foundation (cf. Strahl 1960).

Despite his optimism in regard to scientific criminology and the future possibilities of positive penal law to explain and prevent criminality Kinberg's view of man must still be seen as pessimistic. His medical biological and deterministic stance gave little room for educational and psychotherapeutic methods of treatment (cf. Elwin et al, 1971, pp. 77 f.).

[52] This work was translated into English under the title *Human Mentality* (1933).

[53] Bror Gadelius (1862 1938) has been considered one of the greatest names in Swedish psychiatry (cf. Harding 1975, pp. 10 f.). He was multilingual and well acquainted with international psychiatric literature, which can be seen for example in his doctoral dissertation on the anankastic phenomena (cf. note 34, above).

Gadelius was among the first in Sweden to mention Freud (1896). He continued to show interest in Freud's theories and returned to them in a book written in 1934. Gadelius' critical position has probably contributed to the negative attitude shown by Swedish psychiatrists to the psychodynamic schools even in recent times.

[54] For Gadelius, "catatonic" is equivalent in certain respects to the presently used word "schizophrenic". He also made use of the term precatatonic and with this meant about the same as Kretschmer did with the expression "schizoid".

During the years between the two World Wars, there grew up a psychiatric school, critical of theories of psychopathy. It had its origin in Henrik Sjöbring's (1879–1956) constitutional psychology. From the time of his dissertation (1913), Sjöbring attempted to arrive at fundamental qualities constituting the personality. In his analysis he eventually arrives at four such fundamental dimensions or—as Kinberg (1942) later called them—constitution radicals. These are *capacity* or general intelligence, *validity* or the availability of psychic energy, *stability* or the degree of cyclothymia in Kretschmer's sense, and finally *solidity* or the degree of hysteric disposition.[55]

Like modern personality dimensions Sjöbring's radicals in principle allow a far more differentiated description of personality than do typologies (cf. chap. 7, notes 14, 15). Thus he did not feel it necessary to employ the current psychopath categories. In practical psychiatric work, however, Sjöbring's elevated aims were quickly brought to earth. Primarily due to the absense of physiological as well as psychological measuring devices his system was to a great extent used as a typology. Indeed, in psychiatric journals it is rare to come across any graduated rating of Sjöberg's dimensions, but rather labels such as *subvalid* and *subsolid*. This is remarkable considering the sharp criticism directed by Sjöbring's disciples at the supposed superficiality and diagnostic sloppiness behind "psychopath clichées" (cf. Gerle 1947; 1955).

In the mid-1940s a lively debate broke out over the psychopathy concept between Sjöbrings's pupils and representatives of other viewpoints. One of the reasons was the preparation of a new penal code. Through the special position of so-called psychopaths in criminal law, the concept itself was a center of attention. Psychopathy was defined by the expert members of the appointed committee as "permanent inadequacies in the area of emotions and will, which are manifested primarily in an inability or difficulties to adjust to communal life, and which has its base in hereditary predispositions or diseases or injuries that have occurred so early in childhood as to be decisive for character development" (*SOU 1942:59*,

[55] With "capacity" Sjöbring indicates "the hereditarily based nature of the nerve tissue which is a precondition for intelligence" (Kinberg 1942, p. 353). This variable is like those following assumed to be normally distributed. With "validity" he means the degree of energy available for the physiological processes of the brain. "Stability" has its starting point in the manic-depressive condition. It "indicates the degree to which we can be accustomed, trained or automatized. The substable are those strongly emotional, warm individuals who participate with their whole personality in what happens and only to a lesser degree are automatized. The superstable are those cool or cold creatures of habit who primarily concentrate on facts - - -" (Lundquist 1969, p. 71). The minus variants of this constitution, i.e. the substables, easily fall prey to depressive conditions.

In the hysterical condition Sjöbring finds "the abnormally enlarged expression for his fourth constitution radical" (Kinberg 1942, p. 367). He starts from Janet's observation of the hysteric's tendency to dissociate. For Sjöbring the dissociation depends on a quality of the nerve substrata to be easily "traced" (*baning*) but with the same facility to lose its traces. Psychologically this is expressed in an inadequate firmness, changeability and flightiness. In opposition to it the supersolid are characterized by unchangeability, reliability byt also by inflexibility and "woodenness". Cf. Sjöbring 1958, pp. 143 ff.

p. 43).* Even if somewhat of a compromise had been made with Schneider's psychopathy criterion, in that psychopathy should be hereditary, still it is clear that it is the German views on psychopathy that has been drawn on here.

Criticism from Sjöbring's adherents, on record disclaiming the psychopathy concept in general, was in spite of this based on the German idea of psychopathy. It is one of the many tragicomic aspects of the history of this elusive family of concepts that, when it is believed that the concept as such is being attacked, it is in fact only a single variant which is under fire (cf. note 56, below).

An article written by Kinberg in 1946 is often cited in psychopathy literature: *On the concept of "psychopathy" and the treatment of the so-called "psychopaths".*[56] Here he makes more precise the duties of the physician, which should be to diagnose, that is, "try to state the nature of the disease" (ibid. p. 172) and of course to treat. It is first of all the causes of the disease which should be treated. However, using the current psychopathy concept he finds this impossible. After having reviewed the description of psychopathy as given by a number of authors, he sums up (p. 172):

> One finds in these descriptions of "psychopaths" a hotch-potch of psychiatric, individual psychological, social psychological, characterological and moral distinctive traits. Then there are collected under the same psychiatric term a great many symptoms or conditions of quite different origin.

Kinberg finds this extremely unsatisfactory. Since he and those of his school have, according to their own opinion, managed over a period of thirty years to eliminate the traditionally established concept of imputability (*tillräknelighet*) from Swedish psychiatry, he hardly finds it an impossible task to stamp out the concept of psychopathy, that medical "parvenu - - - derived from common medical thoughtlessness and thought muddle" (ibid. p. 176).

The year after publication of Kinberg's paper, Gerle wrote a similarly critical essay (1947).[57] This author begins with an historic overview of the growth of the psychopathy concept. He then shifts tone and begins a scornful critique. His main attacks are directed at the heterogeneity of this diagnostic category. He finds that the causal factors are many—one must consider heredity, lesion, and environmental influences—and "even with regards to symptomatology we find such a mis-

[56] Kinberg's criticism is relevant above all on the German notions of psychopathy with which he was familiar and probably thought of when writing his article. However, he also cites a number of Anglo-Saxon authors and takes their opinions as further evidence of the heterogeniety of the so-called psychopathy concept. This is admittedly correct in certain respects, but in my opinion it is also an expression of his inadequate insight into the different conceptual traditions of Anglo-Saxon psychiatry in regard to psychopathy.

Kinberg's article has in turn been misunderstood. Thus we find the McCords writing (1964, p. 2): "A minority has maintained that the psychopathic personality, as a distinct clinical syndrome, does not exist". Kinberg is then mentioned and sections of the above article are cited.

[57] In 1955 Gerle published *Personlighetsanalys och psykopatkliché*, which was a revised and expanded edition but similar in content.

cellaneous and disordered design that it can hardly be used as the fencing about the enclosure" (ibid. p. 20).* Gerle concludes his essay with an attempt to show that, with the aid of Sjöbring's constitutional radicals, it is possible to supersede the current psychopath types with a more useful description of the treated personality variations.

Why then was this critique of the concept of psychopathy not generally accepted? To answer this question we can turn for example to the Dane, Hjalmar Helweg (b. 1886) who in 1939 published a textbook in forensic psychiatry which was widely distributed in Scandinavia. In this work he consistently describes psychopathy in accordance with Schneider's typology.

Helweg (1949) finds that Gerle, in his historical analysis of the psychopathy concept "does not really grasp the central idea in the development he is describing" (p. 105). To have nothing but scorn for Schneider's legitimate attempt to divide abnormal personalities into groups is in Helweg's opinion unjust. Schneider's system has won its popularity partly because "the particular types seem to hit something very central" (p. 106).

Helweg also wonders at the astonishing characterological depths to which Gerle considers himself able to plunge, since he judges Schneider's typology to be so superficial as to be comparable to a division of human beings into pale and florid. What is the actual difference between terming an individual *subvalid* and calling him asthenic? Since Sjöbring's brain physiology hypotheses are unproved postulates, Helweg finds no real difference beyond that of terminology. And why, for example, elevate "solidity" to a constitution radical? Would it not be just as well to create a basic variable which reflected trust in the human environment? It could perhaps be called fidelity.

Kinberg and Gerle seem to believe, according to Helweg, that it is possible with the use of Sjöbring's four radicals to give a debth description of a human being's personality. But as a characterological instrument he finds Sjöbring's teachings inadequate. He writes (ibid. p. 110):

> Employing it we are totally unable to characterize and label not only people in general but also those types which are continually appearing among the individuals we call psychopaths.*

Törnqvist (1956) has a similar opinion. After consideration of the assumptions Sjöbring had made in respect to his constitution radicals, he arrives at the conclusion that "those of Sjöbring's theories which are not demonstrably false are unproven or even unprovable for epistemologic reasons" (p. 61).*

Why, then, Törnqvist asks himself, has Sjöbring won, in spite of this, so many adherents in Sweden? He finds the answer to be in part the fact—also pointed out by Husén—that they are dealing with four syndromes long recognized within clinical psychiatry. This gives a feeling of evidence for many psychiatrists.

In summary it can be said that the critique of the Sjöbring school of the psychopathy concept was in part accurate but partially overshot the goal. The criticism

was too general, severe, and lacked nuance. The alternative that was offered was inadequate both theoretically and in practical terms.

In a treatise on the relation of asociality to "psychopathy" K.H. Eriksson (1957) performs a critical analysis of the concept. After a thorough examination of a number of Swedish and foreign psychiatric-criminological investigations he finds that the given frequency of "psychopathy" in each of the related groups varied enormously. He draws the conclusion that this results from "differences of interpretation, definition and utilization of the psychopathy concept and difficulties in making a diagnosis rather than an actual variation in the composition of the different clientele" (ibid. pp. 43 f.). It is hardly possible to come to any other conclusion when, like Eriksson, one is confronted with a variation of between 2 to 87 per cent diagnosed psychopaths in seemingly similar populations.[58]

In order to get a grip on the content of the psychopathy concept, Eriksson undertakes an inventory of those characteristics which have been seen by different authors to be of importance for the diagnosis in question. Working with 52 sources he derives a large number of personality traits or symptoms which are considered to distinguish psychopathy. He collects these into groups and the frequency of each of these groups or "syndromes" is tabulated. The most important syndromes seem then to be (ibid. p. 57):

1) Disorders of emotion and will
2) Adjustment difficulties
3) Abnormal personality variations
4) Impulsiveness
5) Infantility or immaturity.

The author then employs these symptom groups in his investigation but does not venture to use the expression psychopathy, which he has found to be far too controversial and difficult to interpret. Instead he chooses to use the neutral term personality deviation.

Developments in Finland, Denmark and Norway have been largely the same as in Sweden, but in Norway psychoanalysis was early given a positive reception which probably have affected certain Norwegian opinions of psychopathy. However, these questions were primarily handled by psychiatry professor Gabriel Langfeldt (b. 1895) in a number of textbooks and other writings. Initially he adapts a German-inspired concept of psychopathy (1936, 1940, 1947) and seems in his later works (1965a, 1965b, 1976) to advocate a somewhat modified view, but on the whole he remains within the German tradition. In a modern psychiatry text Kringlen (1975) completely abandons the German notions of psychopathy in favor of the Anglo-Saxon (cf. chap. 6, below).

To judge from Friedenreich's textbook psychiatry in Denmark was influenced by the conceptions of degeneration for a longer period than in Sweden. The third

[58] Eriksson refers here to Stouffer et al., *Measurement and Prediction*, Princeton 1950, pp. 475, 553.

edition of this work was published in 1921. However, fifteen years later August Wimmer (1872–1937) published his major handbook on psychiatry with a fair-sized chapter on "constitutional psychopathies", clearly in the German spirit. Other works on the same subject and with the same approach were published during the following years. Helweg's book has already been mentioned, and other authors can be added such as Smith (1939), Reiter (1946) and E. Strömgren (b. 1909). Strömgren's textbook has influenced an entire generation of Scandinavian psychiatrists and also psychologists. It was published in a twelfth edition in 1976. Even in this work psychopathy is described according to the Germans, but later editions reflect other theories to a certain extent.

Finally, the psychopathy concept of the Danish psychoanalytically-oriented psychiatrist Vanggaard is interesting. He criticises Schneider's eagerness to classify, writing that it was this which led him off the track, causing him to construct a system with a "pseudo-scientific clarity that is so foreign from life as to be meaningless" (Vanggaard 1968, p. 279).* Schneider's position demonstrates an inadequate comprehension of what systematics are to be used for. Vanggaard himself claims that there is an obvious experiential difference between an anxious neurotic and an aggressive, uninhibited psychopath, and these should therefore be kept apart even at the scientific level. Accordingly, he will maintain the psychopathy concept along with "neuroses" and "character neuroses".

With the neurotic, character and symptom appear as different kinds of phenomena—the symptom is an element alien to the personality. An equivalent dividing line cannot be drawn between the character of the psychopath and his actions. The latter are, according to Vanggaard, sometimes even premediatated and intended to give as swift a need satisfaction as is possible. A further phenomenological difference is that the neurotic himself suffers as a result of his symptoms, while the psychopathic primarily brings about suffering and difficulties for others. It is only afterwards that he "reaps what he has sown".

The neurotic has a high tolerance for inner states of tension and prefers not to engage in tension-reducing actions which affect others. He therefore is to a high degree in conformity with his society's values and rules of conduct. This makes him a suitable subject for insight therapy which requires tension tolerance. The psychopath on the other hand immediately acts out his anxiety—often destructively. It can thus be seen that the division into two phenomenologically different groups has, according to Vanggaard, not only a descriptive aim but above all a treatment function.

Vanggaard reacts then against the habit in Denmark of considering character neuroses as psychopathies.[59] Character neuroses are for him linked to different

[59] In the Danish Psychiatric Societie's list of diagnosis from 1952 the following two groups of psychopaths or "permanent character deviations of a non psychotic nature" are found: predominantly endogenic character deviations (genuine psychopaths) and predominantly exogenic character deviations (pseudo-psychopaths). In the latter group is found among other conditions "character neuroses" (Strömgren 1958, pp. 327 f.).

neurotic syndromes as for example the anankastic, the hysterical and the anxious.

With the above-named diagnoses (neuroses or symptom neuroses, character neuroses and psychopathies) Vanggaard unlike for example Schneider and Binder does not wish to make a decisive statement on the etiology of the condition. The goal is rather a categorization which can aid in treatment. As a student of psychodynamics he sees in all of them the deformative effects of unsound environmental factors. However, he admits that these will to a varying extent interact with a hereditarily based sensitivity of mind.

5.2.6 Reasons for the Decline of the German Approach to Psychopathy

Despite attempts to infuse new life into the German concept of psychopathy (cf. e.g. Petrilowitsch 1960), its fate seems sealed: it is very likely to disappear. This was foreseen as early as 1948 by the Nestor of the German psychopathy theoreticians, Kurt Schneider (see Stumpfl 1959, p. 5).

One of the most important reasons for this is probably the advances of psychoanalysis. Subsequently, as psychopathologists were made aware of the important role growth environment plays in the formation of the personality—for the healthy as well as the stunted and distorted—the role of heredity as an explanatory factor has been de-emphasized. For Schneider's psychopathy concept, which is to such a great extent built upon an alleged abnormal predisposition, these advances have of course been devastating.

That most psychiatrists have accepted the new discoveries has also meant that psychodynamic theories have been more or less incorporated into psychopathological thought. Especially elements of the psychodynamic theory of neuroses have been accepted and the term neurosis is generally used (but cf. Schneider's opinion, section 5.2.3, above). At the same time, however, an acceptance of the concept of neurosis also meant reduced significance for the psychopathy concept: the more psychopathological phenomena explained in terms of neurosis, the fewer psychopathies.

Since the Second World War the psychodynamic concept of neurosis has been carried along by the rapidly spreading Anglo-Saxon psychiatry and psychology as well as the expansion of the English language. Especially in America the psychoanalytic view of neurosis was accepted at an early date. Therefore by the 1940s, when the mentioned expansion began, the psychodynamic concept of neurosis was already integrated into the conceptual apparatus of American psychiatry.

The influence of Anglo-Saxon psychopathology has also meant that different conceptions of psychopathy have quietly entered and blended with the German. Many diagnosticians in for example Sweden never clearly saw the differences which, despite their common points, exist between these two approaches. A serious confusion resulted, and the psychopathy concept, already troublesome,

due to its multiplicity of meaning, became so problematic that some wanted to reject it entirely. But in recent years the picture has cleared, and "psychopathy" now means for most initiated, at least in Sweden, a behavior complex with such distinguishing characteristics as lack of conscience and empathy, egoism, impulsiveness, and sometimes aggressiveness, carrying with it asociality and criminality.

Finally it can be asked if the construction of the German psychopathy concepts did not in themselves contribute to their fall. Since their creation—to a certain extent as a replacement for the "tainted" concept mental degeneration—their advocates have unsuccessfully fought against a seemingly spontaneous tendency among doctors as well as laymen to delimit their contents. The term psychopathy was from the beginning colored by the asocial variants of the broad abnormal group and acquired a pejorative tone. Consequently through the years it became more and more distasteful for diagnosticians to place the psychopath label on the other categories belonging to the group. In fact, in Schneider's definition of the psychopathic personality (cf. section 5.2.2, above) we can, in my opinion, see something of the intrinsic inconsistency in the concept. He speaks as we know of two phenomenologically different groups: those who suffer from their abnormalities themselves, and those through whose abnormality society is made to suffer.

5.3 Summary

When Koch assembled all those mental disorders which could not be strictly termed mental illness (*Geisteskrankheit*) under the heading *die psychopathischen Minderwertigkeiten*, the basic step was taken towards a separate German development of the originally French theory of degeneration. Koch's artificial systematization of the psychopathic inferiorities never had any real significance but his general concept—and the term he used, "psychopathic"—probably filled a need, since it was taken up so rapidly.

"Psychopathy" (and its synonyms) was to begin with closely tied to the concept of mental degeneration, but it had an important advantage over the latter in that it was not loaded with a lot of connotations from obsolescent theories. When the notion of a mental degeneration subsequently faded from the minds of psychopathologists, the conceptions of psychopathy served to a certain extent as a replacement.

Ziehen was one of that early group of psychopathy theoreticians who functioned to a large extent within the frame of the modified theory of degeneration. (This consisted primarily of the hypotheses of polymorphic heredity.) Most "psychopathic constitutions" were for him inherited mental deficiencies, which sometimes had a stationary character and sometimes expressed themselves as disease processes. He made no clear distinction between these two phenomena.

Kraepelin, on the other hand, did so. In 1904 he introduced an important dis-

tinction between psychopathic disorders of a disease nature—*die originäre Krankheitszustände*—and those which had the character of permanent abnormalities of the affective-conative area. He called the latter *psychopathische Persönlichkeiten.*

Numerous theoretical contributions on psychopathy were published during the 1910s. Perhaps most well-known is Birnbaum's imposing work on the psychopathic criminal (1914). His writings established the term and concept psychopathic personality but also contributed to associating it with asociality and criminality. In his definition Birnbaum strongly emphasizes the factor of predisposition and it is this criterion which was thereafter employed in the German psychopathy concepts, even though practical difficulties kept it from being strictly applied.

During the 1910s some authors also began incorporating intelligence defects into psychopathy; Wilmanns and Gruhle were among those. However, due to the dominating trend within psychiatry, which made a distinction between affective-conative and intellectual disturbances, these psychopathy concepts had short lives.

In creating his typology Kretschmer started from the endogeneous psychoses schizophrenia (dementia praecox) and manic-depressive disease. He finds that the leptosomic and pyknic body types correlate positively with the so-called schizothymic and cyclothymic temperaments, respectively. In the border area between the normal personalities and the psychotic there are also psychopathies which correspond to the temperaments. These psychopathies are called schizoid and cycloid personalities. Kretschmer later works also with an epileptoid personality whom he relates to the athletic body type.

Schneider prefers to begin with the normal personality and considers the abnormal personalities as extreme variations. They can and should be distinguished from psychoses, with which they have no real ties. Like Kraepelin he has the physician's interest primarily in the abnormal personalities that suffer from their abnormalities and those who cause society to suffer. He reserved the name psychopathic personality for these groups. His schema consisting of ten psychopath types has become well known and utilized in Continental-European psychiatry.

Schneider's attempt to create a non-evaluative psychopathy concept failed. The development he wished to prevent, that the concept of psychopathy should be linked to immoral and socially disturbing behavior, could not be checked.

It is possible to discern two lines in the development of the German psychopathy concept up to the time of Kretschmer and Schneider (cf. Heinze 1942, p. 154). The first can be seen as a direct continuation of the view established by degeneration theory, that psychopathy constitute a border zone between mental health and illness. According to this approach there is no real boundary between psychopathy and psychosis, only a gradual transition. Representatives of this position even claim that many psychoses have their roots in a psychopathic predisposition. Ziehen, Wilmanns, Bleuler and Kretschmer are representatives of this tradition.

The other approach has its base in the idea that psychopathy is a stationary abnormal condition, which in its nature is different from mental disease processes. Those embracing this view look upon psychopathies as extreme variants of personality development without any connections with endogeneous psychoses. Koch belongs to this tradition to some extent and so does Kraepelin. Above all, Birnbaum, Jaspers, Gruhle, and Schneider made this distinction. From the 1940s this opinion is dominating in German psychopathology.

Discussion on the nature-nurture problem was growing more intense during the 1940s. The belief in heredity as the basis of most psychopathological conditions had, since the days of the theory of degeneration, been firm, though, admittedly, in those days one also spoke of acquired psychopathic states (e.g. Koch and Ziehen). The heredity investigations of the 1930 also emphasized the etiologic importance of heredity concerning psychopathy and criminality. However, these results were more and more criticized, especially by the psychoanalysts. They stressed the early destructive environment in explaining psychopathic disturbances and they also dissociated themselves from the deep pessimism permeating the traditional psychiatric view on these matters.

From the 1950s the German concept of psychopathy has been declining. Even Schneider did concede that it was imperfect in certain respects and he also anticipated its fall. Some attempts to rescue the traditional German approach to psychopathic phenomena were made by, among others, Petrilowitsch and Binder, but obviously these will not suffice.

The main reason why they and those before them did not succeed is a series of concordant observations that deviant behavior is basically caused by environment. Psychoanalysts paid great attention to this aspect through their concept of neurosis, and they were later supported by experimental research in child psychology. Accordingly the concept of neurosis has successively gained ground on the psychopathy concept.

An additional reason is probably the bredth and heterogeneity of the German notions of psychopathy. Since the times of Koch there has been a tendency among laymen as well as professionals to limit their contents to those abnormal traits that according to Schneider cause society to suffer.

The expansive Anglo-Saxon psychology and psychiatry have also contributed to this development with their different conception of psychopathy, incorporating psychodynamic views.

In France remains of the degeneration theory survived rather long, especially the notion of a family of psychopathological states closely related by a common origin, the polymorphic heredity. Dupré and Delmas, among others, adopted a constitutional view on psychopathic phenomena, basically similar to that of the German. However, the French tended to retain their traditional terminology. Thus they are still making use of Magnan's concept of mental unbalance (cf. section 3.2.3, above) with reference to psychopathy as well as other minor nervous disorders.

In Scandinavia the German view on psychopathy was dominating during the first half of the 20th century. However, in Sweden there appeared a psychiatric school, originated by Sjöbring, which rejected the theories of psychopathy. He and his adherents would substitute them for a dimensional approach, assessing the so-called psychopaths by means of personality variables or "constitutional radicals". This criticism obviously contributed to the decline of the German view on psychopathy, at least in Sweden. Since the 1950s the Anglo-Saxon notion of psychopathy is increasingly gaining ground.

6 Growth of the Modern Anglo-Saxon Psychopathy Concept

6.1 Developments in Great Britain

6.1.1 Debate on the Concept Moral Imbecility

During the first decades of the new century the discussion of moral insanity was closely associated with the formulation of and subsequent interpretational disagreements on the Mental Deficiency Act, which was adopted in 1913 (cf. e.g. Smith 1926, pp. 50 f.). It contained a paragraph on so-called moral imbecility which read in part (cited in Thomas 1926, p. 58):

> Moral imbeciles: that is to say, persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has little or no deterrent effect.

The Royal Commission of the Care and Control of the Feebleminded, which was responsible for the design of the Mental Deficiency Act, had been established earlier, in 1904. Its original proposals were presented in 1908; in conformity with the psychiatric ideas of the time it distinguished between "moral insanity without exaltation or depression, attacking previously normal adults and particularly associated with alcoholism", and "moral idiocy and imbecility present since birth, which could occur in those with good intelligence" (Craft 1966b, p. 18).[1]

One of the medical experts on this commission was A.F. Tredgold. In his *Mental Deficiency (Amentia)*, first published in 1908, he includes discussion of moral imbecility. In his attempt to explain this disorder he turns to the old Scottish psychology of Hutcheson's model: moral imbecility or moral deficiency is taken to result from an inadequate development of the moral faculty (cf. Rush, section 2.-4.1, above). Man has, according to this psychology, four chief senses: the logical or intellectual, the religious, the esthetic and the moral or social. With the last-

[1] Cf. this view of moral insanity with that of Tuke (section 4.4, above). Here, then, an attempt is made to distinguish the moral-insanity syndrome from affective disturbances of depressive as well as exalting nature. Cf. also Clouston's textbook, widely distributed in Britain, in which the author defines his moral insanity concept with a question-answer form (1898, p. 371):

"Have we any examples, where, from disease, a man who had up to that time been moral and conscientious, and obeyed in his conduct the laws and the social observances, but who had lost his moral sense while he retained his intelligence and reasoning power, having no mental exaltation or depression, and in consequence of that diseased moral condition, spoke and acted immorally? I have no hesitation whatever in answering - - - affirmatively, because I have seen such cases".

named, Tredgold means "the faculty of appreciating the obligations due from man to his neighbours as component units of society" (Tredgold 1914, p. 314).

He writes further that these senses can develop differently in different individuals, and this in turn depends partly on inborn predisposition, partly on the environment in which the predisposition has developed (pp. 314 f.):

> Some persons are full of religious feeling, and yet absolutely illogical, inartistic, and immoral. - - - In other instances the aesthetic sentiment may be highly developed whilst the logical sense is lacking - - -.

The author does admit that moral valuations change from time to time, and it is likely "that it is only by the constant force of example, the reiteration of precept, and the infliction of punishment, that the child gradually acquires a sense of the social and legal code of the community in which he lives" (p. 315). But he continues (ibid.):

> The result, however, is not entirely due to the environment. The development of such a feeling necessitates the presence of an innate capacity for its development, and there is every reason for thinking that some persons are so constituted that they are utterly devoid of this potentiality.

It can be seen from the above that Tredgold can conceive of intellectually gifted individuals with a poorly developed moral-social sense. In practise, however, he arrives at a conclusion that is more consonant with the formulation of the Commission above in 1913. He writes that "persistent misconduct of the primary form—that is, that form which is due to innate defect of potentiality, and not to a pernicious upbringing—is closely related to amentia proper—that is, in fact, merely a special variety of primary mental deficiency" (Tredgold 1914, p. 321).

Naturally there are different types of moral defect; Tredgold discerns three subgroups (ibid. pp. 326 f.):

1) The morally perverse or habitually criminal type
2) The facile type
3) The explosive type

Regarding individuals belonging to the first group he writes (ibid. p. 326):

> (They) - - - conform most strictly to the legal definition of moral defect which has been given, inasmuch as their whole lives are one long round of vice and crime, from which they are absolutely undeterred by entreaty, reason, or punishment. - - - They are in fact fundamentally lacking in moral sense, and this, together with the defect of judgement which is always present, causes them to be absolutely irreformable. The condition is inborn, and consequently shows itself in the earliest years.

Those that are of the facile type Tredgold would rather consider to be lacking in will power. They follow with the stream, and their criminality is therefore dependent to a high degree on the attitudes of those around them. He considers further that the majority in this group are women. Many prostitutes probably belong here.

The explosive, finally, have been so named because characteristic for them is

sudden, violent behavior. Tredgold compares it with the motor convulsions of epileptics and points out that certain epileptics demonstrate just this sort of violent aggressiveness. "There is a further resemblance", he writes (ibid. p. 334), "in that, like many of the ordinary epileptics, these persons are often extremely obstinate, intolerant of contradiction, and inclined to be very suspicious".

Tredgold's old-fashioned psychology and the argumentation he derived from it were sharply criticised by the psychology professor Cyril Burt.[2] Certainly it is possible, he writes, to assume an innate potentiality to develop moral sentiments, but in this wide sense nothing human can be developed without such a potentiality. Thus it is similarly justified to treat being able to type-write as an innate capacity.

During a symposium in 1926 at which the definition and diagnosis of moral imbecility were discussed, Burt stated that the term moral imbecile "is a psychological misnomer" (Burt 1926, p. 44). He considers both the noun and the adjective to be unsuitable, and he continues (ibid.):

> The persons contemplated are not "imbeciles" in any intelligible sense of the word: they belong, if anywhere, not to the lower grade of defectives designated by that term, but rather to the higher grade now designated "feeble-minded". Further, "morality" is no longer to be regarded as an innate faculty subject to congenital defects, but as a quality acquired through training and experience.

Burt refers to the nearly 3,000 problem children and young people that he has examined and diagnosed without having had to use the diagnostic term moral imbecile even once. Among these where 116 cases that had been given that diagnosis by others.

Burt was interested in determining which personality characteristics motivated this designation. In his opinion 26 per cent of them are "feeble-minded persons of the ordinary type (the intellectually defective), who happen also to have drifted into vicious or criminal ways" (ibid. p. 12). There are almost as many who are normally gifted without any major instability, but are incorrigible delinquents. A considerable part of the group is, however, mentally unstable, both psychoneurotics with suppressed conflicts causing their asocial behavior, and more hereditarily tainted cases. Consequently Burt's conclusion is that those individuals who run the risk of being diagnosed as moral imbeciles comprise an extremely heterogenous group.

He goes on to analyze the history of the concept and the current explanatory

[2] Cyril L. Burt (1883–1971) is generally considered to be one of the greatest British psychologists. He was influenced by William McDougall (1871–1941), a well-known compatriot of his. Burt began his career by standardising the Binet-Simon test for British conditions. In 1913 he became a school psychologist in London; in 1924 he was appointed Professor of Psychology at London University. For his distinguished contributions he was knighted in 1946, a highly valued official recognition in the United Kingdom. Besides his research on intelligence Burt was known for research into juvenile delinquency and its causes.

attempts. Besides the above-mentioned idea of a moral faculty there was also another, according to which moral imbecility is the result of "an innate deficiency of moral inhibition" (p. 18). This latter opinion is common, Burt writes, among the European writers in the area, such as Lombroso and Kraepelin. Regarding this theory, Burt objects to the positing of "a single center in the brain, with inhibition as its special function" (p. 18).

A third variant, taken from biology, is the theory of a social instinct and resultant moral feelings. It was partly based on the theory of evolution[3] and was influenced by the instinct theory of the psychologist McDougall (cf. note 2). According to Burt also this explanation is a scientifically untenable simplification.

What, then, can be considered to be innate? In the first place, general intelligence and certain special intellectual abilities, secondly, a general instability as well as specific instincts and emotions. Thus it is possible, according to Burt, to speak of "intellectual deficiency" and "temperamental deficiency", but not of "moral deficiency". He has a great faith in the ability of the intellectual functions to maintain control over the emotions and impulses. Accordingly, we read (ibid. p. 29):

> Emotional stability depends on two factors: (i) the strength of the instincts to be controlled, and (ii) the strength of the intelligence controlling them. It might be expressed by the following equation:
>
> $$\text{Instability} = \frac{\text{General emotionality}}{\text{General intelligence}}$$
>
> Thus, a person of average intelligence with excessive instincts would be unstable; similarly, a person of defective intelligence with instincts of no more than average strength would probably be unstable, too; for his instincts would still be too strong to be regulated by such feeble intelligence as he commands.

A similar opinion was voiced by Shrubsall in a contribution to the symposium on moral imbecility (1926). That old question from the age of faculty psychology and the theory of monomanias, of whether the intellect can be undisturbed in the case of emotional or conative disturbances, was revived, then, in the English debate on moral imbecility into the 1920s.[4]

[3] Cf. Darwin's *The Descent of Man* (1871).

[4] That the fixation with this question was so strong in Great Britain probably was due in part to British laws on the mentally ill and the retarded. Since 1843 Britain has followed the so-called McNaghten rules. That year McNaghten attempted to murder the Prime Minister, Robert Peel, but shot his private secretary instead. McNaghten was considered by physicians to be insane. General opinion, aroused by the Royal Family which also feared assassination at that time, grew furious at the statement. The demand was made that McNaghten be hanged. The intensive legal discussions about the case led to the so-called McNaghten rules. These are strongly influenced by the old intellectualistic view of mental illness (cf. section 2.2, above). The person who, due to disease or intellectual defect, shall avoid punishment according to these rules, must be so influenced by his disorder that he is not capable of knowing what he is doing and of understanding whether it is right or wrong; if there are delusions, the delusional facts must be recognized as "real" for the individual. Cf. e.g. Vold 1958, p. 111; Orange 1892, pp. 304 ff.

But why was it that the definition of moral imbecility in the Mental Deficiency Act caused such disagreement and discussion? The answer is probably to be found in the fact that the formulation of the legal text was considered to be far too vague and partially inaccurate.[5] For his part, Burt claims that almost every statement in it left room for discussion. However, he does not see himself as critic but as researcher, intending to determine which individuals the law makers actually referred to, and to redefine the disturbances affecting these individuals in the light of more modern theories and concepts. For example, Burt draws on psychoanalytic results when he comes to grips with the relevant law paragraph, especially the formulation "upon which punishment has little or no deterrent effect" (Burt 1926, p. 40):

> These - - - words are in some ways the most unfortunate addition of all. The inefficacy of punishment appears to have been put forward as a further criterion for proving the innate and incurable character of the criminal and vicious propensities. That, however, implies a very primitive and superficial psychology. - - - As has been pointed out by most analysts of young delinquents, the safest inference from the inefficacy of punishment is the presence of some psycho-neurotic compulsion.

As a result of the sustained criticism directed at certain sections of the Mental Deficiency Act, it was altered in 1927. The most discussed parts of the old text were removed, and the expression moral imbecility was changed to moral defectiveness. With this term was meant persons "in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities and who require care, supervision and control for the protection of others" (Walker 1966, p. 36). Thus the moral imbecility syndrome was still linked to limited intellectual resources. At least, this relationship was required if the so-called moral defective was to be committed to care according to the terms of the above-mentioned law.

6.1.2 Henderson's Psychopathy Concept

With Henderson's[6] and Gillespie's influential *A Text-book of Psychiatry* (1st ed. 1927), Britons were introduced to a psychopathy concept influenced by American as well as German thought. Henderson had worked for a time in the USA and had there been impressed by the opinions of Adolf Meyer (cf. section 6.2.1, below), as is quite evident in his book,[7] but he had also learned from the German psychiatrists (cf. Henderson 1963).

[5] Cf. Burt 1926; Shrubsall 1926; Smith 1926; Thomas 1926; Tredgold 1926.

[6] David K. Henderson (b. 1884) is possibly the most influential British psychiatrist of our century. For some years he worked as a psychiatrist at Adolf Meyer's clinic at Baltimore. He was very impressed by his psychiatry and brought much of his special point of view to Britain. One of the ways in which Henderson's ideas were disseminated was through his textbook, written in collaboration with his younger colleague Gillespie, who died at an early age. In 1932 he was appointed Professor of Psychiatry at the University of Edinburgh. Like Burt (see note 2, above) Henderson was also knighted. In the partly autobiographical *The Evolution of Psychiatry in Scotland* (1964) one can follow his development as a psychiatrist.

[7] The American influence can be seen in part through the fact that psychoneuroses are given an entire chapter in the textbook, and the authors generally follow Freud's division.

Under the chapter heading Mental Defects "emotional and moral defects" are treated as well as retardations in intellectual development. For the former group the authors use an expression originating with Meyer, constitutional psychopathic inferiorities. They define the group in the following way (ibid. pp. 371 f.):

> Under this heading we include persons who have been from childhood or early youth habitually abnormal in their emotional reaction and in their general behaviour, but who do not reach, except perhaps episodically, a degree of abnormality amounting to certifiable insanity, and who show no demonstrable intellectual defect.

It is further clear from the text that, insofar as they sufficiently deviate from the normal, cyclothym and schizothym personalities are usually considered constitutional psychopaths.

From these somewhat fragmentary views on the nature and limits of the psychopathic states the conclusion may perhaps be drawn that the authors consider it to be somewhat of a border condition between mental illness and health—a point of view with which we are not unacquainted (cf. e.g. chap. 5, above). An important criterion for determining when an abnormality has reached the dignified status of being psychopathic is, that it is expressed in criminality.

A significant section of the group psychopathic inferior is labelled as "emotionally unstable". Here are commonly found those who were earlier called moral imbeciles. Also considered to be psychopathically inferior are cleptomaniacs, pyromaniacs, pathological liars and swindlers, eccentric personalities and sexual deviates. A general impression of the psychopathy section of the textbook is, that it appears to be sketchy and reveals the confusion which dominated the area in question. Nor has anything new been introduced in the fourth edition of Henderson's and Gillespie's work (1936). Instead of "constitutional psychopathic inferiorities" the authors, in accordance with developments in America, employ "psychopathic personalities" (cf. section 6.2.5, below).

In 1939 a series of guest lectures on psychopathy delivered by Henderson in the USA were printed in book form. By that time he had for a number of years been increasingly interested in the problem, which he saw as severely neglected. Henderson now prefers to speak of psychopathic states—in fact the title of the book—"because it does not stress unduly either innate or acquired characteristics, and does not imply total mental unsoundness, defect, or delinquency, but yet allows for modification of all of them" (ibid. p. 16). He seems to have gained a certain sympathy for Kraepelin's—and for that matter European psychiatry's—opinions on the personality structure and its significance for the origin of mental disturbances and disease conditions. He writes, e.g., when commenting on Eugen Kahn (cf. chap. 5, note 27) and his observations on psychopathy (ibid p. 21):

> We can all agree with him (Kahn) readily when he states that the make-up of the personality is based on the fundamental factors of its constitution; that environment, while greatly influencing the personality, is merely the medium in which the personality asserts or fails to assert itself; that the problems of the psychopath are just the same as those of other people but that the psychopath meets them in distorted ways.

Henderson does, however, have a more modified opinion than Kraepelin, etc. on what makes up what he terms the constitution. For him the concept is far from being synonymous with hereditary determined. It has anatomical as well as physiological and psychological aspects and takes in environment to the same extent as it does heredity. Here is additional evidence of the influence of Meyer's so-called psychobiology (cf. section 6.2.1, below).

With "psychopathic state" Henderson now intends a constitutional (in the specific meaning noted above) abnormal condition. In his opinion it is very common, not only among criminals but among the general public. He claims for example that researchers such as Bernard Glueck, Bromberg, Thomson and others, who felt that too liberal use has been made of the psychopathy diagnosis within American penology, were mistaken. It is in fact more probable that they have underestimated the frequency of this disturbance.

Further, the psychopathic states seem here—unlike the writer's earlier opinion—to be seen as personality anomalies which are certainly not in themselves stages on the road from health to disease, nevertheless influence to a decisive degree the symptomatology and susceptibility to treatment of mental diseases. Considering this the author writes (ibid. p. 37):

> It is the underlying psychopathic state which constitutes the rock on which our prognosis and treatment in relation to many psychoneurotic and psychotic states becomes shattered.

Thus, behind many of the difficult to cure neuroses, manic-depressive psychoses and schizophrenias he suspects "the influence of dispositional traits of a psychopathic nature" (p. 90).

At the same time that Henderson describes the psychopathic states in the way we have seen above, he seems to maintain his earlier assumed position that these ordinarily express themselves in asocial behavior and criminality. He writes for example that with the term psychopathic state he means individuals "who throughout their lives or from comparatively early age, have exhibited disorders of conduct of an anti-social or asocial nature" (p. 16).

In his description of the clinical manifestations of psychopathy Henderson is content with the utilization of three comprehensive groups which are primarily intended to serve the purpose of simplifying discussion and comparison:

1) Predominantly aggressive
2) Predominantly passive or inadequate
3) Predominantly creative.

The first group includes mainly "(a) those who attempt to injure themselves; (b) those who attempt to injure others; (c) the alcoholic and drug addict; (d) the epileptoid; (e) the sex variants" (p. 38). The author dwells at length on group (a), especially suicides. He sees the spontaneous suicide or attempted suicide as a clear indication of the psychopathic state—"the hasty, aggressive, impulsive action" (p. 40). It further reflects "an emotional immaturity and lack of steadfastness, a predominance of impulse and instinct over reason and judgement, a lack of con-

tinuity in the purpose of life, a failure to meet reality, all of which are such prominent qualities in the constitution of the psychopath" (p. 42).

Certain murderers and robbers also belong in group (a). With these one sees no planning, only "a trigger-like reaction, a short-circuit response" (p. 52). In the description of such cases we recognize many traits from the previously described moral idiot (cf. chap. 4, above).

Aggressiveness is also found in the group predominantly passive or inadequate, but more in the form of a threat than as performed act. If this type of individual has criminal tendencies, he usually exhibits a history of petty criminality. If the picture is more neurotic or psychotic we are more likely to find "the emotionally unstable, erratic, hypochondriacal, nervously exhausted, sensitive, shy, excitable types" (p. 68). Here belong the kind, passive, easily influenced yet also unreliable persons who follow the law of least resistance, and here also appear the pathological liar and swindlar. They are all very difficult to correct.

Henderson ties his third group, the predominantly creative, to the old discussion from the time of the theory of degeneration, on the character and origin of genius. He sympathizes with the opinion "that a brain so highly sensitized as that of the genius is one which is particularly liable to fail - - - under the heavy strain which it has to carry" (p. 97). He continues (ibid.):

> I, therefore, come to think of genius as being associated with a state of mental imbalance, of heightened sensitivity, of disordered mental equilibrium due probably to the attempt to get square with reality and even more to dominate reality as a compensation for the inner unresolved conflicts which dominate conduct. This attempt at domination is on an analogous basis to the attempt of the aggressive and inadequate psychopath to control the situation just as the genius does, who, more than any other, shows an intermixture of aggressive and inadequate trends.

It is probable that Henderson has been inspired by the *dégénéré supérieur* of French psychiatry (cf. section 3.2.3, above). Accordingly, in choosing examples of pronounced creative psychopaths he picks out two singular personalities who are extremely gifted according to the judgement of the day: Jeanne d'Arc and Lawrence of Arabia.

What then can be found in common between such people and the aggressive impulse murderer—or the lax, weak-willed individual who with no twinge of conscience yields to the slightest pressure? According to Henderson they are all "combined by instability, queerness, explosiveness, intuitiveness and eccentricity' (ibid. p. 103).

Henderson points out in the foreword to his work that the views he expresses are preliminary. If he means that he himself is uncertain as to what is to be comprehended in the concept psychopathic states, it is perhaps easier to understand his book's lack of precision. In spite of its easily flowing style it is especially unsatisfactory on several points. For example, Henderson uses the concepts neurosis and psychosis, but how does he limit their content in relation to "psychopathic states"? The text gives us no answer.

6.1.3 Continuing Developments in Great Britain

Curran & Mallinson (1944) begin their careful article on the psychopathy concept with an observation that is obviously valid, yet often neglected in psychopathologic debate. They write (p. 266):

> The discussion of any topic is handicapped as long as there are doubts and disagreement as to what is being discussed.

Behind the various descriptions and definitions they seek common characteristics, thereby reducing the number of psychopathy conceptions to a minimum. Their survey of the literature comprehends Continental as well as Anglo-Saxon authors. According to their findings many writers are agreed in calling certain kinds of behavior psychopathic. *Psychopathic reactions* are distinguished "by their transient, episodic, uncontrolled and often explosive character" (ibid. p. 280). Further, they are to a great extent dependent on environment. There are also certain people that tend to be called *psychopathic personalities*, "namely, those *par excellence*, who indulge repeatedly in anti-social acts, amongst whom the family blacksheep or nightmare, and certain types of criminal, are well-known examples" (p. 280).

It is possible, according to Curran & Mallinson, to encounter a drift between both of these positions while reading the same author; another problem is that psychopathy in the one sence may be defined with the aid of the other, and vice versa. From the conception of a psychopathic personality, then, one infers psychopathic reactions, and the manifestation of so-called psychopathic reactions leads easily to the conclusion that we are dealing with a permanent psychopathic condition, that is, a psychopathic personality. To this one may add the fact that many psychopathic reactions and states are socially undesirable. Some writers have placed greatest weight on this point as a criterion of psychopathy.

Despite the conceptual disarray the authors believe they have been able to discern the following three main standpoints (p. 282):

1) The conception of psychopathy as shown by persistant abnormality of character;
2) The conception of psychopathy as shown by episodic "short circuit" reactions;
3) The conception of psychopathy as shown by asocial or antisocial behavior.

Curran & Mallinson draw the conclusion that three categories have been and are focused when use is made of the diagnoses psychopathic personality or its synonyms. These are: (a) the vulnerable personalities; (b) unusual or abnormal personalities or characters; and (c) sociopathic personalities (pp. 282 f.).

The vulnerable personalities are defined as "potentially unstable individuals or bad psychiatric risks" (p. 382). This perspective on psychopathy reminds us of the original French view of the phenomenon in question (cf. chap. 3). The group under (b) includes a long row of different personalities which are relatively stable, yet deviate from the norm. This view of psychopathy is much like that of Kraepelin

and Schneider (cf. sections 5.1.3 and 5.2.2, above). The group under point (c), finally, sociopathic personalities, is defined by their asocial or antisocial behavior. Among this group the writers of the article relate, that they have sometimes distinguished between "predominantly inadequate personalities" and "predominantly aggressive" (p. 283). The most prominent advocate of this point of view is probably Partridge (cf. section 6.2.4, below).

Curran & Mallinson conclude their article with a number of observations including the following (p. 284):

> If the above is a fair summary of the present position, the discussion of the prognosis and treatment of all these various types of vulnerable, unusual, abnormal and sociopathic characters, now all lumped together as psychopathic personalities, must embrace so many factors that it cannot profitably be undertaken before more agreement has been reached on questions of definition and delimitation.

To judge from this quotation the psychopathy concept was relatively heterogeneous in Great Britain at the middle of the 1940s. This is substantiated in another paper written by Anderson (1962) who states, that for a time Henderson's psychopathy concept had considerable official support. Anderson reviews primarily those discussions on psychopathy carried on by the Royal Commission of 1954. Its task was to prepare a law dealing with mental illness and mental deficiency. The committee members expressed their preference for a relatively comprehensive psychopathy concept; to judge from the description they were influenced by Henderson's view on the question. What actually happened was, according to Anderson, that the legal concept moral defectiveness was quite simply renamed—in line with current usage—psychopathic personality, "without making any significant addition to knowledge of the problem to that of the symposiasts of 1926" (ibid. p. 250). By way of summary Anderson writes (ibid.):

> Thus nomenclature in England for this group of anti-social individuals has progressed from "moral insanity" to "moral imbecility" to "moral defect" and finally to "psychopathic personality".

Anderson, who is critical of Anglo-Saxon psychiatry, which he feels lacks clinical preciseness, prefers Schneider's theory of psychopathy. He himself has attempted to contribute to its dissemination by making himself responsible for the English version of *Die psychopathische Persönlichkeiten* (cf. section 5.2.2, above).

However, Schneider has had a more influential spokesman in Britain, Mayer-Gross.[8] He did not want to adopt Schneider's classification system in its entirety, but through the massive *Clinical Psychiatry* (1st ed. 1954), released together with

[8] Willy Mayer-Gross (1889–1961) received his psychiatric schooling in Heidelberg and was strongly impressed by among others Gruhle and Jaspers (cf. section 5.1.4; and chap. 5, note 29). In 1933 he came to Great Britain, where he had a notable influence. He opposed much in Adolf Meyer's and Henderson's psychiatry, which he considered too loose. His own point of view, expressed in *Clinical Psychiatry*, was German-inspired but rather eclectic.

E. Slater and M. Roth, Schneider's viewpoint on psychopathy has been given considerable exposure. The authors explain it in an admirably lucid manner, summarizing their point of view in the following sentences (Mayer-Gross et al. 1960, p. 117):

> There is no theoretically satisfactory way of distinguishing between so-called psychopathic and so-called neurotic personalities. Neurotic symptoms and psychopathic behavior can alike be considered as reactions determined, on the one hand by constitutional predisposition, on the other by environmental stresses.

Accordingly, psychopathic personalities and neurotic reactions are integrated into the same chapter.

Mayer-Gross and his co-authors seem, however, to have had only limited success with their German-inspired view of psychopathy and neurosis (cf. e.g. Craft 1966a, and below). Referring to the approach of traditional British psychiatry to the problem of psychopathy Slater and Roth (Mayer-Gross died in 1961) write resignedly in the third edition of the handbook (1969, pp. 59 f.):

> The attempt to delimit psychopathy as a clinical syndrome has now become fossilized in the Mental Health Act (1959). Section 4 (4) reads: "In this act 'psychopathic disorder' means a persistant disorder or disability of the mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment". In effect this clause equates "psychopathic disorder" with anti-social conduct. Persons coming within the definition make up a group with no common clinical or aetiological feature. - - - It is unfortunate that a modern statute, of prime significance to psychiatry in this country, should be conceptually so ill-founded.

According to Craft (1966b, pp. 1 f.) The Royal Commission's (see above) investigations seem to reflect "the general feeling in Britain that the psychopathic disorder was only the obvious, smallest, and extreme fraction of the iceberg of behavior disorders of which there are many in the community sea". Craft had this impression reinforced at a conference for prison doctors and hospital psychiatrists held in 1962, where they were also questioned on their views on psychopathy. Six prison doctors were of the opinion that, aside from antisocial behavior, psychopaths exhibited (1) aggressiveness; (2) tendency to act impulsively; (3) a defective ability to empathize; and—more doubtful—(4) inability to learn from certain types of experience, as, for example, punishment.

After further investigation of the state of opinion, which confirmed his impression, Craft now believes that medical experts in the area should be able to agree on the following traits as distinctive for psychopathy (ibid. pp. 5 f.):

Positive Features

a) Primary

(1) A lack of feeling quality to other humans, described by some as affectionlessness and others as lovelessness. In extreme cases he may be quite without feeling sense.

(2) A liability to act on impulse and without forethought. This relates to the old legal phrase "irresistable impulse".

b) Secondary, deriving from the above

(3) A combination of the previous two, under suitable circumstances, leading to aggression.

(4) A lack of shame and remorse for what has been done.

(5) An inability to profit by, or use experience; which includes a lack of response to punishment. The antisocial quality of their actions may have been recorded in the past by way of conviction.

(6) A lack of drive or motivation, leading to a general inadequacy of conduct, so that the person does not use his apparent abilities.

c) Additional

(7) With the above the presence of a viciousness, or wish to do damage to things or persons.

Negative features

(1) Lack of psychoses, such as schizophrenia or depression, which are excluded on psychiatric examination.

(2) Lack of pure intellectual deficit or mental ability less than half the average man, so that on testing he scores a standard Binet I.Q. of under 50.[9]

(3) Lack of criminal motivation of planning of actions in the light of risks at issue.

The picture of the psychopath given by Craft in the above points is largely in agreement with those descriptions met in contemporary American literature in the area (see sections 6.2.7; 6.2.8; 6.2.9; 6.3).

6.2 Developments in America

6.2.1 The Contribution of Adolf Meyer

At the turn of the century psychiatry in the USA was underdeveloped. The few physicians working in large institutions had neither the time nor the energy for anything more than their administrative duties and routine treatment of patients. Research was something that only a few—most often at the price of much lost sleep—were able to give attention to. The situation with education was just as bad. It was primarily conducted *ex cathedra* and presented a traditional systematized and simplified picture of psychiatric reality (see Meyer 1951d, pp. 386 ff.). In other words American psychiatry was at this time primarily "an institutional and legal task" (Meyer 1928/29, p. 2).

Meyer[10] entered this stagnant, seemingly hopeless world, bringing with him new and fruitful ideas. The first thing he accomplished was to introduce

[9] With this unclear statement, which unfortunately betrays a surprising lack of knowledge of testing theory, the author probably intends, what he says in the dependent clause, that the border should be around IQ 50. Possibly he might also have been thinking of the first quartile or 25th percentile, that is, the point on the IQ scale reached by 25 per cent of the normal population. However, this point is approximately equivalent to IQ 90.

[10] Adolf Meyer (1886–1950) was born into the family of a Zwinglian priest in Switzerland. The

Americans, little schooled in the German language, to research-oriented German psychiatry. In a number of articles (which also demonstrate Meyer's knowledge of the history of psychiatry), he introduced his American colleagues to the new approach to psychiatric inquiry taken by Kraepelin, Wernicke and others.[11]

That which probably disturbed him most in American psychiatry of the day was its committment to an outdated classificaiton, uninspired routine diagnosis and in conjunction with this practically meaningless statistics kept at the hospitals.[12]

During the years just after the turn of the century Meyer played an important role conveying ideas from European psychiatry to America. But he was hardly an uncritical advocate, and shaped what he borrowed according to his own theories. Subsequently he drew further away from German models and developed his own so-called psychobiological school.

It was primarily through Meyer that American psychiatry became acquainted with the German psychopathy concept. As early as 1903, in an article titled *An Attempt at Analysis of the Neurotic Constitution*, Meyer showed a concern with "the psychopathic-neurotic type",[13] which he feels had been handled far too schematically and dogmatically within the frame of degeneration theory. In spite of his skeptical approach to psychiatric clssification, he is far from rejecting this aid. Indeed, he finds it useful to employ those groups which crystallize out, so to speak, before the psysician's scrutiny. The aim is to reach mental constitution types which can give leads as to what kind of disease the individual concerned risks developing.

father was of an undogmatic nature and encouraged his son to think critically and to question everything. The mother came from a family of doctors, so that the young Adolf's choice of profession is not surprising. He had high ambitions and early traveled abroad, studying medicine in Paris and London before he came to Chicago, hired as a pathologist at the age of 26. From 1895 on he conducted neuropathological research at a mental hospital in Massachusetts, but became increasingly interested in clinical work because neuropathology gave him few if any answers to psychiatric questions. He was soon convinced of the importance of environment in the development of mental diseases. During the first decades of the 20th century Meyer was to make important contributions to clinical as well as theoretic psychiatry in New York. His methods, for example his conscientious, systematized recording of anamnesis, was later disseminated through the country. In 1910 he was appointed Professor at Johns Hopkins in Baltimore. Meyer is without doubt the most prominent figure of the century in American psychiatry. Cf. e.g. Diethelm 1959.

[11] The somewhat older German psychiatry of the Krafft-Ebing model had its American spokesman in the neurologist Spitzka (cf. section 3.2.4; and chap. 2, note 63).

[12] "The superstition about the value of a diagnosis of a disease", writes Meyer in 1905, "prompts many to believe that a diagnosis once made puts them into a position to solve the queries about the case not with the facts presented by it - - - but by a system of rules and deductions from the meaning of the newly defined disease entities, with their prognosis and autotoxic and other origin held out to the believer as sufficiently settled for practical purposes" (Meyer 1951a, p. 136).

[13] What is the origin of Meyer's expression "the psychopathic-neurotic type"? In articles from this time (Meyer 1951c, 1951d), he often refers to Ziehen, who used the term *psychopathische und neuropathische Constitution* (cf. chap. 5 note 2, above). It is possible that in this case Meyer's choice of term was influenced by Ziehen. He also chooses to speak of "constitutional inferiority", where the first half of the combination leads one to think of Ziehen's *psychopathische Konstitution*. The second half on the other hand can probably be traced to Koch's *Minderwertigkeiten*.

However, according to Meyer such constitutional types are not necessarily hereditary. Before taking a position in that question, the physician should carefully determine the facts in the case. Psychiatry must, as Meyer sees it, remove itself from the level at which the facile diagnosis degeneration is considered to be scientifically satisfactory.[14]

In 1905 Meyer presented a classification of psychopathological phenomena, which he divides into three major groups. In group (A) he places "the diseases which depend on a fairly tangible interference with the brain or its nutrition" (Meyer 1951a). In group (B) we find along with other conditions dementia praecox and manic-depressive psychosis. In group (C) Meyer gathers the mental disorders ("psychoses") "that really form part of the so-called general neuroses or of simple constitutional inferiority or involve fundamental defects of make-up and development". He lists the following "psychoses belonging to definite neuroses or make-up" (ibid. p. 144):

1. Neurasthenic.
2. Psychasthenic.
3. Epileptic.
4. Hysterical.
5. Constitutional inferiority and abnormal make-up, with or without outbreaks.
6. Idiocy and imbecility.

Concerning group (5), with which we are especially concerned in the present study, Meyer writes (p. 144):

> Since many of these disorders are compounds difficult to disentangle, and quite a few obviously belonging to this group do not show the characteristics of any of the recognized "neuroses", we provide for a group of psychoses of constitutional inferiority arising from peculiar make-up but not already provided for in the large groups A and B.

From the point of view of definition, then, the category constitutional inferiority is a remainder of anomalies which has found no place in the other groups. Thus it is far from comparable with Koch's *psychopathische Minderwertigkeiten* (cf. section 5.1.1, above). It is, rather, equivalent to Ziehen's *die allgemeine degenerative psychopathische Konstitution* (see section 5.1.2, above), except that Meyer's category has no tie to degeneration theory. As vaguely defined as it was, however, it rapidly gained a content that Meyer had not foreseen.

Gurvitz (1951/52), attempting to relate the development of the psychopathy concept during the 20th century, ascribes to Meyer the role of the one who

[14] On this point Meyer clearly sets himself apart from most contemporary colleagues. His undogmatic attitude is also shown by his interest in the ideas of psychoanalysts. For that matter, he also took part in arranging Freud's lecture series in the USA in 1909, and he met him in person when he, Jung and Ferenczi arrived in the New World. Freud seems to have greatly appreciated that Meyer, one of America's greatest psychiatrists, showed him this interest. See Ruitenbeck 1966, pp. 27 ff. Later Meyer became more critical of psychoanalysis but was never moved to emotionally colored condemnations as were many of his colleagues—especially those in Europe.

originally drew the line between that which we now mean with neurosis and psychopathy respectively. He writes (p. 88):

> Meyer took the important step of excluding the neuroses from this classification (Koch's psychopathic inferiorities).

But as we saw above, this was not the case. Meyer distinguishes between what was then termed neuroses (neurasthenia, psychasthenia, hysteria, epilepsy) and those constitutional inferiority conditions of a more undetermined, hence more difficult to classify variety. That which made his distinction appear to be significant was the later development of the neurosis and psychopathy concepts.

The psychodynamic view of the neurosis as an expression of an intra-psychic conflict was rapidly disseminated within American psychiatry, and the turn of the century meaning of the term in question thereby disappeared (cf. Ruitenbeek 1966; Shakow & Rapaport 1964). The concept constitutional inferiority also underwent a change and was increasingly associated with concepts originating with German psychiatry: psychopathic inferiority, psychopathic constitution and psychopathic personality. The picture was complicated by the fact that Meyer's concept became a kind of replacement for the moral insanity concept, which after the major debates on the subject during the 1880s fell increasingly into disuse (cf. section 2.6.2).

6.2.2 Other Early Opinions on Psychopathy

In 1912 Oberndorf stated in an article that Meyer's term constitutional inferiority had been rapidly picked up and incorporated into American psychiatric nomenclature and thus filled a need. However, in one way the term is a misnomer, since the word "inferior" unavoidably leads the thought to "mental debility". Through this false association there has been collected under the heading constitutional inferiority "all varieties of constitutional abnormality from the mentally defective, i.e. the congenitally high-grade imbecile - - - to those who are brilliant though asymmetrically developed" (Oberndorf 1912, p. 249).

Oberndorf himself is of the opinion that this widely comprehensive group can be divided into two kinds of inferiority: a qualitative and a quantitative. He uses qualitative inferiority for those who are highly gifted in certain areas, but despite these preconditions lack "the determination and poise to complete cleverly though impulsively conceived plans" (ibid. p. 250). These are the individuals termed by the French *déséquilibrés*. With quantitative inferiority the author intends those more evenly underdeveloped personalities who demonstrate intellectual as well as moral defects. However, he wishes to separate the more severe grades of mental retardation. The group in question seems to be closely related to the category called "moral imbeciles" in Britain at that time (cf. section 6.1.1, above).

The year after Oberndorf's paper, Karpas' contribution appeared; this gives a

good example of the conceptual confusion which reigned in this area during the 1910s in America. Karpas writes (1913, p. 594):

> According to many authorities, the group of psychic inferiority is restricted to the intellectual domain only, and no recognition is given to the other two faculties, emotion and volition, which are equally important.

Therefore he wish to propose his own definition (p. 594):

> By psychic constitutional inferiority we mean a defect (usually congenital) in the emotional, volitional, or intellectual sphere, more than one faculty may be affected. As a result of this there is a loss of mental equilibrium to such an extent as to make one incapable of adjusting himself to environmental influences.

Inferiority states are then divided into three groups, an emotional, a volitional and an intellectual. The emotional form contains hypo- as well as hyperaffective variants. Among the hypoaffective is found "the shut-in personality" which, to judge from Karpas' description, is similar to Kretschmer's schizoid psychopath. The hyperaffective group contains cases of manic and hysterical states.

Most important in this context is, however, the volitional form, "one of the most striking in the field of psychopathology" (ibid. p. 595). The author comments on this group (ibid.):

> It is rather interesting that the individuals are usually intelligent and educated, and there is no congenital defect in the intellectual faculty. Individuals of this class are frequently known as 'the black sheep of the family'. Without exaggeration it may be said that a large majority of our criminals, tramps, vagrants, prostitutes, chronic alcoholics, habitues of drugs, and the like, come under this class.

In an article three years later (1916) Karpas treated the different categories in more detail. Here he showed that he still thought along the lines of the old faculty psychology, and to judge from the continued exposition he considers the volitional variant of constitutional inferiority to be equivalent to moral insanity, even if he avoids the use of that expression.

The psychiatrist and criminologist W. Healy includes consideration of the concept constitutional inferiority in his comprehensive work *The Individual Delinquent* (1915). He defines it, in accordance with Meyer, by exclusion, as "chronic abnormal social and mental reactions to the ordinary conditions of life, on the part of one who cannot be classified in any of the groups of insanities, neuroses, or mental defectives" (Healy 1924, p. 575).

This was followed by a more detailed presentation of the content which showed the great extent, to which the author had been influenced by German psychiatry. Consequently, his view on the subject is considerably different from that of Karpas, referred to above. Healy explicitly rejects the concept moral insanity which in his opinion has only lend to confusion. It appears to him to be remains from the outdated moral sense philosophy (cf. section 2.4.3). Probably because of this attitude he does not see any link whatsoever between the moral insanity concept and psychic constitutional inferiority.

Healy states further that the English-language contributions to psychopathy have been sparse indeed, while the French and Germans have been greatly occupied with the question. Thereafter he refers to a number of German authors in the area, which he seems to have read in the original. He himself describes the psychopath, or the constitutional inferior as he prefers to call him, in the following way (ibid. pp. 576 f.):

> The general characteristic of the constitutional inferior is abnormal reaction to some of the ordinary stimuli of life. Unusual emotional reactions are almost universal in members of this class. They are often egocentrical, selfish, irritable, very suggestible, easily fatigued mentally. Sometimes they are possessed by an abnormal feeling of impotence. They may be slightly defective in intelligence or have light, specialized defects of ability, but very often tests reveal neither defect nor peculiarity. Indeed some members of this class may be regarded as distinctly bright, even geniuses, although weak in power to meet the steady demands of the world. - - - Not the least feature of the symptomatology of this class of individuals is the ease with which they fall into anti-social conduct. The attraction towards misdeeds is too much for their weak inhibitory powers in many a case, or their very feeling of social impotence leads to their taking the easiest path. The ranks of vagabondage, tramp life, as may well be imagined, are recruited in considerable part from this class.

6.2.3 The Psychopathy Symposium of 1923

In 1923 the then young psychiatrist Ben Karpman arranged a symposium on the theme of psychopathy, to be held at St. Elizabeth's Hospital in Washington. Eight speakers contributed, illuminating different aspects of the multi-fasceted field. The symposium was the first more systematic contribution to psychopathy research in America.[15]

In his introductory paper Karpman stated that opinions are obviously divided among experts as to what shall be comprehended under the term psychopathy and its synonyms. He posed a number of intricate questions which he hoped the symposium participants might be able to answer, at least in part.

White finds in his analysis that the psychopathy concept has become "a wastebasket into which all sorts of things have been thrown" (Karpman 1924, p. 175). He continues: "It is a sort of middle ground for the dumping of odds and ends, as the praecox group used to be" (ibid.). White directs his fire especially at psychopathy synonyms in which the word constitutional is found, for in his opinion it implies hereditary disturbance. With our lack of knowledge we should, he feels, hold the question of psychopathy's etiology open until we are more sure of the actual conditions.

Johnson, who was given the task of handling terminology, found it especially elusive. However, he himself contributes yet another term, "psychosatipath", since characteristic of the psychopath is behavior intended to satisfy personal

[15] Investigations carried on by Healy and B. Glueck among others had points of contact with psychopathy research but were primarily criminological.

wants, in spite of this not being accepted by "the herd". Neither does Johnson believe that psychopathy is hereditary, and expresses his feeling with the aphoristic "the psychosatipath is made, not born" (ibid. p. 178).

Silk's view of psychopathy differs most from the opinions of the other participants. According to him psychopathy consists of three distinct symptom groups. The first he calls constitutional organic inferiority. The second group, which he terms, surprisingly enough, psychopathic personalities, indcates a sensitive-schizoid personality type. Silk calls the third and final group constitutional psychopath or social psychopath, by which he means disturbances of adjustment, "mostly at the social level, being usually acquired" (ibid. p. 180). He further describes them as being "very alert, very aggressive, and markedly egoistic and narcissistic" (p. 181). He considers that cases of *Pseudologia phantastica* are examples falling in this group.

Scheetz emphasizes the lack of logic in the psychopaths' reasoning, and their poor judgement. He writes (ibid. p. 188):

> They are self-centered, self-loving, obeying instinctively the law of self-preservation, which takes no thought for the welfare or well being of others, and acting as if the immediate present were the only thing to be taken into account. Their conscious activity seems ruled almost entirely by the "feeling" aspect, instead of by thought and reflection. While they appear intelligent, they have a peculiar twist in their mental make-up that amounts to a defect in their power of discriminating between values.

Richmond attempts to distinguish between psychopathy and psychoneurosis. He finds that the two concepts partially overlap, "but the underlying mechanisms are so different, that in many cases it is not difficult to determine with which of the two conditions we are dealing in a particular case" (ibid. p. 189). The neurotic child, for example, is abnormally sensitive, sleeps poorly, is often hurt interacting with his peers. He prefers therefore to play with younger children or escape to his parents. Most often he develops into a daydreamer or heavy reader. The psychopathic child on the other hand has a nature hard as steel. "He is unteachable—not that he does not learn, but he learns, apparently, only what he chooses" (pp. 190 f.). To this can be added a superficiality in emotional life that astonishes even the layman.

Dooley describes the psychopathic woman in about the same terms that others have used to describe the asocial, egocentric and now-oriented male psychopath. She most often has sexual relations but is an especially bad wife and mother. Attempts to treat her psychoanalytically usually fail, since her desire to change is seldom sincere.

Karpman distinguishes between the psychotic criminal, the psychoneurotic criminal, the defective criminal, and the psychopathic criminal. He writes (ibid. p. 199):

> In the psychopaths we have unstable individuals with marked volitional and temperamental, but not obviously intellectual defects, who are the criminals *par excellence*, their criminality resulting from psychopathic difficulties and maladjustments which eventually bring them into conflict with the law.

Karpman summarizes (p. 200):

We have in the psychopathic criminal a type of criminal quite different from all others—different in his original personality make-up, different in the reason for his criminal behavior, and different in his mental reaction towards crime and confinement.

Lastly, O'Mally writes on psychoanalytic treatment of psychopaths and agrees with Dooley, that it is seldom successful. Central is the narcissism of the psychopath, which is constantly fed by the analyst's interest in him. Her conclusion is that the psychopath does not actually wish to be cured. Therefore this type of therapy is impossible.

The symposium showed many opinions concerning the content and scope of the psychopathy diagnosis. However, one finds a tendency in most contributions to reserve "psychopathy" for a syndrome containing such traits as egoism, ruthlessness, aggressiveness, impulsivity, proneness to criminality etc. As regards the etiology the majority of the participators did not want to take up a definite position.

6.2.4 Partridge: Sociopathy

Towards the end of the 1920s the psychologist G.E. Partridge began a research project intended to clarify the vague diagnosis psychopathic personality. In his historical review (1930/31) he finds it difficult to gain a firm grasp on developments in America with regard to such concepts as constitutional inferiority, constitutional psychopathic inferiority, constitutional psychopathic personality, constitutional psychopathic state and psychopathic personality.[16] However, the word constitutional tends to fall into disuse "as views shift away from the conception of definite inherited conditions" (ibid. p. 61). The expression psychopathic personality, though, is winning ground.[17]

Partridge's first report (1927/28) consists of a systematic investigation of 50 hospital journals of patients who had been diagnosed as psychopathic per-

[16] Partridge writes that it is difficult to completely distinguish individual contributions. On one occasion he had verbally inquired of Meyer, when he had employed the expression psychopathic inferiority for the first time. The answer was, in 1908 in connection with the Thaw case. As presented above (section 6.2.1) Meyer had spoken in 1905 of "constitutional inferiority". Either he did not remember this at the time of his conversation with Partridge, which does not seem likely, or else he means exactly what he says, that is was not until 1908 that he first began to employ the term psychopathic inferiority.

[17] Parallel with the disappearance of the attribute constitutional used in conjunction with psychopathy, the use of the word inferiority was also dropped. The expression constitutional psychopathic inferiority was, however, not rejected entirely. It was found, e.g. in American immigration laws, still valid during the 1920s (see Partridge 1930/31 p. 61). At Phipp's Clinic in Baltimore, where Meyer worked, it seems, according to Dr. Greenacre (ibid. p. 63) that the terms constitutional psychopathic inferiority and constitutional psychopathic personality were used at the same time, but not as synonyms. The latter concept represented a more specific personality development, while "constitutional psychopathic inferior" beared upon individuals with constitutional defects in general.

sonalities. It seems to him that the characteristics they exhibit can be divided into three groups. He calls them (1) the delinquent type; (2) the inadequate type; and (3) the general incompatible type. To judge from the case descriptions the groups were very heterogeneous.

It appears (Partridge 1927/28, 1930/31) that the concept psychopathic personality had by that time been given considerable breadth. Referring to this, the author writes (1930/31, p. 54):

> The tendency has been to eke out a respectable number by placing in the category all persons who show decided personality distortions—whatever that will mean, at the same time relieving the other classes of many troublesome cases. In some usages the group becomes almost the unclassified remainder of mental disorders.[18]

In its widest significance the concept in question seems to include all sorts of personality deviations.[19]

On another occassion (1928/29) Partridge presents psychopathic behavior as a special kind of adjustment to the demands of society. Notable here is that needs and desires may well be satisfied with the aid of infantile devices such as attacks of rage, stubbornness, parasitism, etc. He emphasizes that we are not dealing with a special illness or psychopathological entity. Strictly speaking there are, according to him, no psychopaths, only more or less psychopathic reactions in people. However, he does consider it practical that individuals with more predominant psychopathic traits should be placed in a special group.

It is further evident that Partridge considers his view on the psychopathic pattern of adaptation to be a guarantee against psychoses rather than early stages in their development. Hence his view of psychopathy is in this respect totally different than for example Kretschmer's (cf. section 5.2.1, above). However, at an investigation Partridge carries out, he finds that a number of psychoses had been preceded by distinct psychopathy. Despite this he writes (ibid. p. 517):

> The evidence is quite to the contrary of the assumption that might be drawn from this, that psychopathic adjustments are especially likely to lead to psychoses or that the severity of the mental illness is in positive correlation with the perfection of the psychopathic method of adjustment.

In his 1930/31 paper Partridge presents his main contribution to the debate on psychopathy. Starting from the lack of knowledge which his investigations of the field have revealed, he asks himself whether one is justified in distinguishing a

[18] As we saw above (section 6.2.1) it was Meyer's original thought that the category constitutional inferiority should, for the time, being have the character of a remainder group. Healy's definition of psychic constitutional inferiority (1915) followed this line (cf. section 6.2.2, above).

[19] As an example of the shifting use of the concept psychopathic personality Partridge refers to Healy, who considered that out of 4,000 delinquents he could only designate three per cent as psychopathic personalities, while Gregory, after an investigation carried out in New York State prisons, considered 77 per cent to be psychopaths (see Partridge 1930/31 p. 92). Cf. note 28, below.

group called psychopathic personality. He is doubtful about this, if with the concept one includes such separate phenomena as antisocial "stable non-psychosis-producing deviations, the pre-psychotic mal-adjustments" and "slight psychoses" (p. 57). This group of disparate deviations might perhaps be called "pathological personalities".[20]

With the confusing situation that exists, Partridge suggests that an attempt be made to identify and distinguish an important group within the category psychopathic personality, that is, those individuals who have problems with their social behavior. He writes (ibid. p. 55):

> If we may use the term "sociopathy" to mean anything deviated or pathological in social relations, whether of individuals with one another, or within or towards groups, and also in the relations of groups to one another, we have a fairly communicable meaning, and a term which we may apply descriptively to a great number of persons.

Of course problems arise when trying to distinguish "the essential sociopath" (p. 57) from other individuals with less deeply grounded antisocial behavior. However, the problem is no greater in this context than when setting up other psychopathological distinctions. Important criteria for differential diagnosis are, according to the author, the following (p. 56):

> They (the essential sociopaths) display long-continued mal-adjustments and their behavior is not readily corrected and brought into the normal social pattern by any ordinary methods of education or punitive technique.

With the use of these criteria the group becomes far too inclusive, for there are neurotic as well as psychotic states whose symptoms include asocial or criminal behavior difficult to correct. But with the pronounced sociopaths Partridge also discerns a deeply rooted antisocial motivation, which he does not find in other conditions showing surface similarities. This motivation criterion was important for the delimitation of the sociopath group.

Experience has taught, however, that such "inner" phenomena are difficult to employ in practise. How is the occurrence of deep antisocial motivation to be established? Of course, by pointing out certain persistently recurring, hence difficult to correct, criminal behavior. To the extent that one attempts to use Partridge's motivation criterion, then, it seems most often to be the same as his first criterion for sociopathic behavior, "persistent and consistent anti-social behavior".

Partridge's description of sociopathy has certain similarities with the concept moral insanity, which had been discarded by this time. Thus he was to link up with an old diagnostic tradition within Anglo-Saxon psychiatry. This probably had significance for the future of the concept and the term, even if there was no im-

[20] "*Patologisk personlighet*" (pathological personality) is the official Swedish designation for that comprehensive group of deviations which was called *Psychopathische Persönlichkeiten* in the German-language literature. How and when the expression pathological personality originated is not known to me.

mediate interest shown in Partridge's viewpoints within American psychiatry and criminology.[21] In his "sociopathy" an intermediary link can be seen between "moral insanity" and the later narrow American psychopathy concept (cf. below, sections 6.2.7; 6.2.8; 6.2.9; 6.3). Partridge's term achieved official status, when "sociopathy" was included in the *Diagnostic and Statistical Manual of Mental Disorders* adopted by the American Psychiatric Association in 1952.

6.2.5 Psychopathy Diagnosis around 1940

In chapter 30 of the collection of writings edited by Hunt, *Personality and the Behavior Disorders* (1944), Preu writes of the concept psychopathic personality. In an elucidating fashion he summarizes the content of the psychopathy concept in America at that time. The diagnosis psychopathic personality is, in his opinion, usually arrived at in the following manner (Preu 1944, pp. 924 f.):

1) An individual who has given evidence of outspoken mal-adjustment is brought to the attention of the psychiatrist. A psychiatric problem is assumed to be present since social maladjustment exists.

2) The diagnosis of psychopathic personality will be considered if the maladjustment has been continuous or repetedly recurrent over a long period of time, particularly if the problem behavior has proved resistant to presumably adequate treatment.

3) The difficulty in adjustment may have been manifested by any kind of symptom or behavioral pattern, provided that it has not been manifested by symptoms clearly indicating defective intelligence, structural disease of the brain, epilepsy, the neuroses, manic-depressive psychosis, or schizophrenia.

It can be seen from the above that two characteristics are important in the context, continued social maladjustment, and difficulty including the observed deviation within one of the other psychiatric categories. They are certainly not new to us. The social element has actually been with us since the very beginnings of the development of psychopathy concepts. It existed, as I see it, in a vague form with Prichard (cf. section 2.6.1) and gained increased importance when the area of the moral insanity concept was restricted. The social connection also exists with the German notions of psychopathy, despite its being actively opposed.[22] It is first with Partridge (cf. section 6.2.4, above) that chronic social maladjustment was accorded the rank of criterion *par preference* for psychopathy—or sociopathy, as Partridge preferred to say.

Preu's second criterion has a history in America going back to Meyer's definition of constitutional inferiority. As mentioned above (see section 6.2.1) this group was defined through exclusion. In clinical work the exclusion criterion for psy-

[21] Cleckley (1964, p. 248) considers that Partridge's contribution to the psychopathy debate was "largely ignored by many authorities".

[22] Cf. Schneider's reasoning, section 5.2.3, above.

chopathy has played a certain practical role also in German psychiatry, which can be seen for example with E. Bleuler (see section 5.2.1, above).

However, there are different sorts of social maladjustment. The following five indications of maladjustment have, according to Preu, been ascribed symptomatic importance:

1) "Delinquency and law-breaking in general, including both minor misdemeanors such as truancy, petty stealing, promiscuity and prostitution as well as serious crimes such as larceny, forgery, and murder" (ibid. p. 925). Delinquency of one kind or another is the most used of all criteria for the diagnosis of psychopathic personality.

2) Unconventional behavior, which seriously disturbe relations with other people.

3) Emotional instability or other affective deviations that have serious effect on social relations.

4) Aberrant sexual behavior.[23]

5) Narcotic addiction and chronic alcoholism are considered by many as a sign of psychopathy.[24]

As regards differential diagnosis between manic-depressive psychosis and schizophrenia on the one hand and psychopathy on the other, the following seems to apply (p. 926):

> If the symptoms which suggest a manic-depressive or schizophrenic condition are mild, a diagnosis of psychopathic personality is usually made, sometimes with the qualifying adjective schizoid or cycloid. - - - On the occasion in which both psychopathic personality and manic-depressive psychosis or schizophrenia are diagnosed, it is commonly assumed that the two conditions are separate and distinct, not that the psychosis is an outgrowth or extension of the psychopathy - - -.[25]

Finally, it is, according to Preu, the case that individuals earlier classified as neurotics can be given the diagnosis psychopathic personality, if the symptoms remain or the social maladjustment does not cease, in spite of the fact that adequate treatment (according to prevailing judgement) has been given.

Regarding the etiology of psychopathy, opinions are divided, but the majority still consider the psychopath to be in one way or another "hereditarily doomed to defective development" (p. 927). According to Preu the psychopath is placed in the group "constitutional defectives"[26] by Henderson & Gillespie (1930), Henry

[23] Many clinicians have, however, seen this as expression of neurotic conflict. Cf. e.g. Karpman's opinion (1941b; and below, section 6.2.7).

[24] Also on this point there is much disagreement. Cf. e.g. Cleckley's veiw (1959; 1964; and below, section 6.2.8).

[25] This corresponds with Partridge's view (cf. section 6.2.4, above). Cf. also the discussion on this question in German psychiatry (section 5.2).

[26] Preu points to the important fact that with the word constitutional Meyer did not only mean something hereditary but also early acquired, habitual modes of reaction. This usage, however, was never widely employed with the result that Meyer's use of the term is often misunderstood. Cf. Henderson's view in the question (section 6.1.2, above).

(1938), Muncie (1939) and Strecker & Ebaugh (1940).[27]

The author emphasizes that psychopathic personality as he describes it is not comparable with other psychiatric diagnostic entities. It is in fact no more than "a diagnosis of convenience arrived at by a process of exclusion" (ibid. p. 936). No single symptom or symptom complex considered to be a sign of psychopathy is specific for this condition. In spite of this the diagnosis is accepted, and qualified psychiatrists do not hesitate to employ it. Why? According to Preu one of the reasons is simply that psychiatrists, like other physicians, are reluctant to label a patient "undiagnosed". After all "psychopathy" indicates a psychiatric problem. Additionally, it has significance for categorization within institutions and in matters of forensic psychiatry.

Despite the disagreement in the area, one notes in Preu's article that a certain homogenizing of the psychopathy concept had taken place since the beginning of the 1920s. Around 1940 "psychopathy" in America was closely associated with asociality and criminality—so closely, that for many the concept was nearly synonymous with "habitual criminality".[28]

Finally, it should be noted that according to the official "Statistical Guide" (see Cleckley 1947) the category Psychopathic Personality included, in addition to antisocial personalities, also schizoid, cycloid, paranoid as well as sexually deviate personalities, hence along with other opinions also reflected the German views on psychopathy. However, Cleckley (ibid.) claims that this official concept became increasingly obsolete (for more on this see section 6.1.8, below). In the *Diagnostic and Statistical Manual* of 1952 the above-named heterogeneous group is placed under the collective heading "Personality disorders". The narrower yet relatively comprehensive concept described by Preu has an equivalent in this nomenclature: the category Sociopathic Personality Disturbance. The nuclear group indicated by Cleckley, Karpman, the McCords, etc., is included under the diagnosis Sociopathic Personality Disturbance: Antisocial Reaction (cf. sections 6.2.7; 6.2.8; 6.2.9; 6.3).

6.2.6 Views of Psychoanalysis on Psychopathy

Psychoanalytic theories have not, as is well-known, applied only to neuroses, but have also been employed in many other contexts. As early as 1915 Freud[29] con-

[27] Of these authors, Henderson & Gillespie (1927; 1936; 1944) and Strecker & Ebaugh (1940) have been available to me. All of the authors mentioned were influenced by Adolf Meyer (cf. 6.2.1, above).

[28] McCord & McCord (1964, p. 39) write: "At an Illinois State prison 98 per cent of the inmates were labelled 'psychopathic'. At another midwestern prison psychiatrists diagnosed only 5 per cent as 'psychopathic'. The diagnosis of sex offenders offers another example of this confusion: 52 per cent at New York's Bellevue Hospital were called 'psychopathic', but only 15 per cent who appeared before the New York's Courts' psychiatric clinic were so titled. Obviously, these institutions meant very different things when they spoke of psychopathy". Cf. note 19, above; and Karpman 1941a, p. 112; 1952, pp. 65 ff.

[29] Sigmund Freud (1856–1939) is of course far too famed to require introduction here. There is

sidered the area of criminality and its causes. In the essay *Some Character Types met with in Psychoanalytic Work* he describes among other things criminality from a sense of guilt. In his practice he had encountered patients who had committed criminal acts, not, as might be assumed, through greed or desire to revolt and be revenged, but through strong irrational guilt feelings. According to Freud it was these feelings that drove forth the crime and not vice-versa.

On account of such cases he poses two questions: Where do the heavy guilt feelings come from, and to what extent is human law breaking a result of these feelings? Regarding the first question he writes (ibid. p. 343):

> The invariable result of analytic work is that this obscure sense of guilt derives from the Oedipus-complex and is a reaction to the two great criminal intentions of killing the father and having sexual relations with the mother. In comparison with these two, to be sure, the crimes committed in order to account for the sense of guilt were comparatively light ones for the sufferer to bear.

Freud cannot answer the second question but he speculates that the connection referred to between guilt and crime can be found in most lawbreakers, though of course it plays a greater or lesser role in each case.

Freud's essay was written before he had completed his so-called structural theory, that is, the division of the psyche into the id, the ego and the superego. First presented in 1923 in *Das Ich und das Es*, this theory has also come to be used in the attempts of psychoanalysts to explain asocial and criminal behavior.

According to Freud the superego develops as a result of the solution of the Oedipal conflict; the child subsequently submits to the demands of reality. A normal superego functions as a brake on the sexual, aggressive and other impulses. If, however, this psychic structure is undeveloped or warped, it lacks the ability to repress the impulses of the id and dissolute behavior is the result.

This is fairly much the point of view one meets in Aichhorn's pioneering work *Verwahrloste Jugend* (1925).[30] In a foreword to the book, Freud writes that his own contribution to the utilization of psychoanalysis in child-rearing has been meagre. He finds, however, that it is child psychology and related disciplines that seem to have had the most benefit from his theories.

In ten pedagogically skillful lectures Aichhorn combines psychoanalytic theory with the upbringing of asocial children and youth. Asociality and criminality are for him symptoms, and therefore he strives to get at the causes. These he sees in the constellation of mental forces created by the emotional relationships of early childhood. Poverty, bad company, etc., that is those factors people usually give as causes, for him only act as triggers—they make the latent asociality manifest.

a rich literature on him and his psychoanalysis. The most comprehensive work *The Life and Work of Sigmund Freud* (1953–57, 3 vols), is written by the psychoanalyst Ernest Jones. A shorter, but probably historically more accurate picture of him can be found in Ellenberger's *The Discovery of the Unconscious* (1970).

[30] Aichhorn's book was translated into English under the title *Wayward Youth* (1936).

Aichhorn's idea of the origin of behavioral disturbances and asociality contrasts strongly with the theories of psychopathy and criminality held by other psychiatrists at that time.

Aichhorn distinguishes two groups of disturbances: neurotic borderline cases, in which an unconscious conflict is found, and more clear-cut asocial. He feels it important to differentiate between the two categories, because they cannot be brought up in the same way. It is much more difficult to establish an emotional rapport—the prerequisite for all pedagogical influence—with the clear-cut asocial child than with the neurotic one. The former has a great hatred of society and thus is very suspicious and distant.

In his tenth lecture Aichhorn speaks of the significance of the "ego ideal" for social existance. The term *Ichideal* is then used synonymously with *Über-Ich* (superego).[31] After having described this psychic structure he states (ibid. p. 275):

By the asocial it can only be a matter of an ego ideal - - - which is different from that of other people.*

The same year that Aichhorn's work was published (1925), Abraham[32] wrote a much noticed article on the fraud N. He met him for the first time in 1918, when, in the capacity of army physician, he gave a psychiatric statement on him. N. was then 22 years old with a long row of the most fantastic sorts of fraud behind him. The man had an extraordinary ability to win the confidence of others, and he exercised this natural gift to the fullest in his criminal endeavors. In 1923 Abraham was once more called upon to make a statement on N. At that time it was shown that since 1919 he had not been guilty of any criminal act. In that year N. had made the acquaintance of a widow, who was considerably older than he was. She had fallen in love with him, offered him well-paid and socially well-situated employment, and soon after, they were wed.

Abraham's conclusion was the following. Because of his loveless childhood N. had not been able to resolve his oedipal conflict and had remained at an earlier, primarily autoerotic or narcissistic stage. Consequently he was unable to invest his libido in other persons to any greater extent. The woman he married came, however, to represent the mother for him. "The father", that is to say the woman's husband, had been long since dead and hence was no threat. N. was then able to love his "mother" undisturbed, and with her he achieved what he could never

[31] The term superego appears for the first time in 1923 in the above named *Das Ich und das Es*. Thus it was completely new when Aichhorn wrote his book. He also mentions in passing that Freud has spoken of *Über-Ich* as well as *Ichideal* (see Aichhorn 1925, p. 272).

[32] Karl Abraham (1877–1925) was the first psychoanalyst in Germany and one of the most prominent of Freud's early disciples. Jones (1955 p. 5) writes in the foreword to Abraham's *Clinical Papers and Essays on Psycho-Analysis*:

"Abraham was the most mature of the first generation of those who accepted Freud's discoveries and theories. His rich clinical experience, both in psychopathology and in clinical psychiatry, combined with his keen powers of observation and his cool critical judgment give to his contributions a quite special value in a field where such qualities are of the highest importance".

achieve in his childhood: "the full gratification by a mother-substitute not only of his longing for maternal tenderness, but also of his erotic desires" (ibid. p. 302). Thereby he progressed from the narcissistic fixation of his libido in the direction of object-love.

In 1925 Wilhelm Reich's[33] *Der triebhafte Character* was published, in which he treated questions concerning psychoanalytic treatment of impulse-driven personalities. In the better-known *Characteranalyse* (1933)[34] Reich describes several additional personality variants and the special character armours in which these attire themselves. He then speaks of the hysterical character, the compulsive character and the phallic-narcissistic character. The last of these is of interest in the present context, for the author considers that most cases of so-called moral insanity belong to this group.

Towards the end of the 1920s the later famed psychoanalytic author Franz Alexander (1891—1964) formulated a theory in which he attempted to summarize the experience gained by that time. "The tendency which psycho-analysis has been showing of late", he writes (Alexander 1930, p. 292)[35] "is that of laying emphasis upon the patient's personality as a whole". This has made it possible to understand persons whose problems are not manifested in limited mental symptoms but in deviate behavior. He calls that type of disturbance neurotic character.[36] Those who suffer from it do not display an "autoplastic mode of in-

[33] Wilhelm Reich (1897—1957), originally Austrian physician and psychoanalyst. Reich is best known for his theory of sexuality. In his work during the 1920s as the head of Vienna's psychoanalytic policlinic, which was open to the poor of the city, Reich became convinced that the patriarchal, capitalistic and anti-sexual societal system was the cause of the neuroses. He worked with the concept of neurotic character (cf. note 36, below), including in it the physical posture and the muscle armor neurotics employ to hide their true selves. When Hitler came to power Reich left Germany and stayed in Norway, Denmark and Sweden until 1939, when he emigrated to the USA.

[34] Reich's book *Charakteranalyse* was received enthusiastically by many psychoanalysts. Its technical instructions were considered to be "(one of the) clearest and most unequivocal contributions that have yet appeared in psychoanalytic literature" (cited in Reich 1949, p. xiv). The work was translated into English under the title *Character Analysis* (1945).

[35] This paper is the revision of a lecture held in 1927 in Innsbruck, Austria.

[36] Here Alexander refers to Freud's article from 1915 (see above) and to his *Beyond the Pleasure Principle* (1st ed. 1920). The label neurotic character is resonant with Freud's method of expression in this book. Alexander writes (1930, p. 295): "(It) - - - was intended to convey the idea that the neurotic element manifested its presence in these individuals not so much in the form of circumscribed symptoms as in the character, that is to say, it permeates the patient's personality and thus influences his total behavior".

That sounds like a good definition of the ego-syntonic neuroses commonly called character neuroses. What then is the difference between neurotic character and character neurosis? It is doubtful if there has ever been a clearly discernable difference (cf. English & English 1958, p. 346). As we saw above, Alexander wishes to limit the content of the concept neurotic character to apply only to the "acting out" neurotics. With Reich on the other hand the concept is much wider. He even questions whether it is justified to differentiate symptom neuroses and character neuroses. He writes e.g. (Reich 1949, pp. 41 ff.):

"Quite some time ago, Glover worked on the problem of differentiating character neuroses from symptom neuroses. Alexander also operated on the basis of this distinction. In my earlier writings I also followed it. More exact comparison of the cases showed, however, that this distinction makes

stinct gratification" (ibid. p. 292)[37] but act out their impulses—often in an asocial direction. However, one is mistaken to assume that these individuals lack a conscience. Their behavior reveals the existence of a superego as well as something typical for the neurotic: an unconscious conflict between different parts of the personality.

What sort of disturbance is it that Alexander more thoroughly handles with his concept? He writes (ibid. pp. 297 f.):

I - - - refer to those individuals whose lives are full of dramatic action, to whom something is always happening, as if they were literally driven by the demonic compulsion which Freud once metaphorically imputed to them. These are the individuals whose whole lives can be interpreted as clearly as an isolated neurotic symptom, for every transformation and permutation remains the unmistakeable manifestation of the same unconscious conflict. Here is where the adventurers belong whose manifold activities give expression to an underlying revolt against public authority.

Here then are to be found the many criminals who are driven to break the law because of unconscious conflicts. In this group Alexander places for example a certain Catholic priest, who seemed to do all in his power to miscredit his calling and the church. He was of Jewish descent but broke in a sensational way with the faith of his family. Afterwards it was the turn of the Catholic Church to be the object of his wrath. As Alexander sees it, the religious institutions became unconscious father images, upon which the priest must be revenged at any price.

In youth, neurotic characters often have no feeling of personal difficulties: "They present mostly the picture of vigorous, joyful dare-devils" (ibid. p. 308). Subsequently, however, some of them gain insight into how trapped they are by their behavior patterns, and a few even seek psychotherapeutic aid.

An important question to be asked now is why one individual "chooses" an

sense only insofar as there are neuroses with circumscribed symptoms and others without them; the former were called 'symptom neuroses', the latter 'character neuroses'. In the former, understandably, the symptoms are more obvious, in the latter the neurotic character traits. But, we must ask, are there symptoms without a neurotic reaction basis, in other words, without a neurotic character? The difference between the character neuroses and the symptom neuroses is only that in the latter the neurotic character produced symptoms, that it became concentrated in them, as it were. If one recognizes the fact that the basis of a symptom neurosis is always a neurotic character, then it is clear that we shall have to deal with character-neurotic resistances in *every* analysis, that every analysis must be a character-analysis".

The passage above illuminates which meaning a couple of prominent psychoanalysts ascribe the concepts under consideration, around 1930.

[37] "Alloplastic and autoplastic adaptation. Terms introduced by F. Alexander (1930) to distinguish between adaptive responses which alter the environment and those which alter the self", writes Rycroft (1972, pp. 5 f.) in his psychoanalytic reference book. However, the terms in question probably do not originate with Alexander, even if he made them more well-known through use in his article. Reich (1949, p. 159) suggests this when he writes:

"Following up the theory of Lamarck, Freud and Ferenczi distinguished an autoplastic and alloplastic adaptation in psychic life. The latter means that the organism, in order to exist, changes the outer world (technique, civilization); the former means that it changes itself. Biologically speaking character formation is an autoplastic function".

autoplastic behavior, while another chooses an alloplastic. Alexander believes that the "choice" is finally a question of constitution. Thus he writes (pp. 307 f.):

I believe that it is decisively significant whether or not the individual is inclined toward autoplastic gratification of his impulses. Without an autoplastic disposition no neurosis is conceivable. Unquestionably a specifically constitutional factor is primarily responsible for this quality of the fundamental impulses.

In *Roots of Crime* (1935) published in collaboration with Healy, this basic view is still maintained (see p. 289). Aside from the importance that "certain unaquired bases of the instinctive life (constitution)" (ibid. p. 289) have for future character development, the authors arrive at the following results in their investigation (pp. 287 ff.):

The main difference which our investigation was able to establish between the developmental history of psychoneuroses and criminal careers is the greater emphasis in criminals on certain conscious and rational motives which are co-determinants of their behavior and which they utilize for covering up the underlying and usually more powerful unconscious emotional motives. - - - In summary, where actual motives of need coincide with parallel emotional conflict situations, there is a greater likelihood of criminal behavior than of neurosis because rational needs can hardly be satisfied by the symbolic gratifications which the neurotic symptoms supply.

An article entitled *The Criminal Psychopath in the Psychoanalytic System* was published by Wittels in 1937. It touches on the hyperpromiscuous, pathological liars, thieves, swindlers, frauds and murderers, but Wittels dwells longest on the first group which he designates "the primal representation of the psychopath" (p. 276).

With his article he wishes to prove that this sort of psychopath is libidinously fixated in Freud's phallic phase, "in point of fact, in the first part of this phase in which the sex differences are not as yet recognized as decisive" (p. 276).

The Don Juan figure has earlier been interpreted psychoanalytically as that tragic character who repeatedly seeks his coveted mother. In the same manner he "kills" his father, again and again. This theory has, according to the author, a degree of validity but only in respect to "the neurotic, medieval-Christian Don Juan". In contrast to the latter stands the classic renaissance figure who" knows neither fear nor defence of any internal dangers". (p. 276). Wittels continues (ibid.):

The very fact that he does not know what a father is makes him so terrible: he is praeoedipal. - - - He knows no mother-respect either. He is obviously as potent as the devil and imbibes life in all its ramifications in deep, joyful draughts.

According to Wittels this type suppresses neither the masculine nor feminine traits within him, but exploits and enjoys them all. He understands women, thanks to his feminine traits; for example he dances well, cries and smiles with them. But he can also be very masculine, "at times brutal, fearless, trouble-seeking, and

gratifies his paramours with unbroken sexual efficiency (p. 277).[38] It is Wittel's opinion that this psychopath does not experience any great degree of guilt, due to the very fact that he does accept the bisexual nature of his character.

In his famed *Rebel Without a Cause* Lindner (1944) depicts the penetrating hypnoanalysis of a criminal psychopath.[39] His conclusion is the following (p. 7):

> There seems to be little doubt that the special features of psychopathic behavior derive from a profound hatred of the father analytically determined by way of the inadequate resolution of the Oedipus conflict and strengthened through fears of castration. Now since the father (or his surrogate) is the channel through which society - - - is introjected, and since the father is hated and resented, the super-ego is correspondingly under-developed.

The author continues (pp. 8 f.):

> That the psychopath is burdened with guilt and literally seeks punishment has been observed by the author in countless cases. The clue to this strange situation lies, as one would suspect, in the Oedipus situation. Deprived of an avenue to satisfactory post-Oedipal adjustment and continuously beset by consequent incest and parricidal phantasies, the emergent guilt can be assuaged only through expiation. "I have sinned against my father and I must be punished" is the unverbalized theme of psychopathic conduct - - -.

Friedlander (1947) puts forth the idea that psychoanalysis, unlike other theories in the area, primarily emphasizes the similarities between the criminal and the non-criminal. She writes, e.g. (p. 27):

> The antisocial urges - - - met with in the delinquent are normal manifestations of the instinctive life of the small child and - - - the preoccupation of delinquents with their desires and pleasures is equally manifest in the toddler.

It then becomes important to determine how the normal child, who begins by only following his impulses, eventually becomes capable of mastering them and channeling his impulsive energy into socially acceptable paths. Such knowledge, to which psychoanalysis has contributed much, is according to Friedlander a basic precondition for understanding personality development in the criminal.

The author's description of what she calls "common offenders" is similar in many ways to definitions of a psychopath. She writes (ibid. p. 110):

> They are narcissistic and emotionally infantile, unable to stand any tension, while their desires and their grasp of reality in so far as it serves the gratification of their desires are already those of an adult.

Behind this behavior Friedlander finds an antisocial character formation with a fixation mainly in the anal-sadistic phase. Characteristic for this group is a sado-masochistic relationship to the environment. With certain juvenile delinquents this relationship is so established that the mildest provocation immediately leads to antisocial reactions.

[38] Cf. the Servin case, referred to by Rush 1786 (section 2.4.1).

[39] Lindner comprices the narrow psychopathy concept of Cleckley's model (cf. section 6.2.8, below).

Like other psychoanalysts, Friedlander does not use the expression psychopathy or its synonyms. She considers the concept psychopathic personality to be "as vague and as open to misinterpretations as was the former conception of 'moral insanity' " (ibid. p. 138). But, with certain reservations, she does seem to find Henderson's psychopath descriptions (see section 6.1.2, above) useful, especially "the predominantly aggressive type" and the "predominantly passive or inadequate type".

In a lecture delivered at a criminology congress held in Paris, 1952, Karpman presented an overview of the contributions of American psychoanalysts to criminology during the period 1937–1949. He finds that most of them consider the terms criminality and psychopathy to be synonyms. The majority sees criminality as a specific form of neurosis. However, some claim that there are certain law breakers "which do not fit into the definition of neurosis or psychosis, but must be regarded as primarily psychopathic, the presumption being that the latter is chiefly, or at least largely, constitutional" (Karpman 1952, p. 65).

Karpman finds no real agreement among the psychoanalytic authors in the area.[40] Each one presents a new attempt at interpretation. They all begin with the psycho-sexual development stages, but disagree as to which phase the primary fixation took place at. Some claim "that criminal behavior arises at the oedipal level, while others believe that psychopathy has a fixation point in Freud's phallic phase and that the reaction has its origin at a pregenital level. Special types of criminality have been traced to oral fixation" (ibid. p. 69).

But what are the opinions regarding the causes of this arrested development? Certain authors find parental rejection of the child to be etiologically significant, others fall back on Freud's idea that unconscious guilt plays an important role (cf. above).

The psychopath or the gravely criminal is considered by most to be psychoanalytically untreatable, for it does not seem possible to take analysis so far that a transference occurs. Some claim, however, that all persons are treatable, but the methods must be adapted to the personalities of those undergoing analysis.

6.2.7 Karpman's Psychopathy Concept

In 1941 Karpman (1941a) wrote a paper in which he develops a line of thought touched on by him as early as 1924, i.e. making the diagnosis of psychopathic personality more uniform. This shall be done by separating those conditions that should in his opinion rather be placed in other psychiatric categories. Karpman

[40] This statement seems difficult to accept. It is probable that Karpman considers certain basic viewpoints common to all psychoanalysts to be so obvious that he neglects to name them. Important in our context is e.g. the psychoanalytical socialization theory, in the light of which the psychopath stands as an individual, early injured by environment with grave inadequacies, especially in superego functions. Cf. e.g. the citation from Lindner above, and note 54, below.

proposes that from "psychopathy" in its broad sense one should create two concepts: symptomatic and idiopathic psychopathy. He claims that those who have worked with the psychopathic states easily appreciate that the group is far too broad to be included in a single diagnosis. The author considers that, just as epilepsy was divided into two kinds, a genuine and a symptomatic, he is motivated to do the same with the concept psychopathic personality. Treating the proposed division he writes (ibid. p. 113):

> I group under Symptomatic Psychopathy all those reactions that on the surface bear close resemblance to what we call psychopathic behavior, except that in these cases it is not difficult to elicit psychogenesis which is behind the psychopathic indulgence. Under the term Idiopathic Psychopathy (Anethopathy) we include reactions that are in every sense of the word psychopathic as we have come to know and understand these reactions; but search as we may and regardless of what efforts we seem to make to trace the psychopathy to any known or existing psychogenic factors, we always meet failure.

Karpman was to expand this basic thought in a number of articles during the following decade (1941b; 1947/48; 1948a; 1948b; 1949; 1950). He, like many other American psychiatrists, early absorbed the psychoanalytic concept of neurosis, the central idea of which is that neurotic symptoms are the expression of intra-psychic conflicts. Studying the so-called psychopathic personalities he noted a similar dynamic in most of them. In spite of their psychopathic behavior, then, most of them appeared to him to be basically neurotic.

However, there remained a small group of psychopaths whose behavior—despite considerable searching on Karpman's part—was not explained by any psychodynamics. They exhibited no deeper mental conflicts, no shame or guilt feelings, no regret—in short, Karpman considered himself to have found individuals without a conscience.[41] It is to this small, but from many standpoints important, group that he refers with his concept idopathic psychopathy or anethopathy. He expresses the hope, certainly, that some of these "genuine" psychopaths will during a more effective future analysis be found to belong to the symptomatic group, but he is convinced that there will always be a remaining "small number of individuals who apparently cannot be grouped under any other heading than Idiopathic Psychopathy (Anethopathy)" (Karpman 1941a, p. 113).

In his first article on the subject referred to here (1941a) the author presents in detail two cases intended to illuminate the two groups. The example of the idiopathic psychopath has not, however, for certain readers been very convincing. It is difficult to build a real idea of the patient's growth environment, since the lack of data from that period is astonishingly great. However, Karpman states that it is in fact this that is characteristic for the condition in question: it is not possible to obtain information which might explain the psychopathic behavior. His critics,

[41] Karpman's description of the idiopathic psychopath seems to echo older depictions of moral idiots and born criminals (cf. chapt. 4, above). However, in those of Karpman's works which I have read, there is no reference to such literature.

though, have difficulty in following this line of reasoning. One of them says for example in discussion of the subject (Karpman 1949, pp. 184 f.):

It would seem to me that all human behavior, including the extreme forms of psychopathic behavior, is dynamically determined. - - - It is difficult for me to conceive of a congenital inability to develop a super-ego except where there is serious demonstrable organic pathology of the brain.

In the opinion of many, characteristics such as mendacity, impulsiveness, inability to postpone pleasure or learn from experience, antisocial behavior, etc., are specific psychopathic attributes. Karpman, however, shows that all of these traits can be evidenced in other psychopathological conditions. He maintains, then, his opinion that the above-mentioned personality traits in the psychopath are not generated by inner conflicts, but depend on what is probably a genetically-based inability to develop certain human qualities. For example in one of his many articles on the subject we find (1947/48, p. 529)

The true psychopath lacks completely the basic capacity to acquire repression and thus grows up with a total inability to defer pleasure and sacrifice immediate gain.

It is different with the neurotic. He and the psychopath are, according to Karpman "in terms of basic personality miles apart" (ibid. p. 525). With "primary" psychopathy, even after extended analysis, it is not possible to find a psychogenesis of the disorder. "It just isn't there!" the author exclaims, with a weakness for exaggerated expressions. However, the behavior of the neurotic and the psychopathic can on the other hand be puzzlingly similar, because guilt and anxiety—characteristic phenomena in neurosis—are also occasionally expressed in aggressiveness and antisocial behavior.[42]

What Karpman is especially upset about in American psychiatry is the tendency to be satisfied with the descriptive level, rather than striving to get behind the manifested behavior and get hold of the dymanics of the deviation. In his opinion that is the reason why sexual perversions—the paraphiliac neuroses, as Karpman calls them—in America are referred to the category psychopathic personalities, despite the fact that a depth analysis consistently seems to show that such neuroses are caused by deep underlying neurotic conflicts (see Karpman 1941b).[43]

[42] Karpman later (1961) made an ambitious attempt to systematically distinguish between neurosis, psychopathy and psychosis. These three categories must in his opinion be carefully distinguished, something psychiatry has not been quite successful with. From our viewpoint, however, the article is of little interest, since Karpman is only engaged in making more precise his special view of psychopathy, and that we have already reviewed.

[43] The primary reason should, in my opinion, be the influence of German psychiatry with its special views on psychopathy.

6.2.8 Cleckley's Psychopathy Concept

In 1941 a work on psychopathy was published which would be of considerable importance for the further development of the concept in America. Its title reads *The Mask of Sanity* and the author is the psychiatrist Hervey Cleckley.[44] The book was later published in a number of revised editions, the fourth in 1964. The title of the book has reference to Cleckley's expressed opinion that psychopathy is a serious disease—in many respects comparable to psychosis. It can, however, be even more treacherous, for the behavior of the psychopath has an appearance of rationality. One is easily lead to believe that a normally equipped person is being dealt with, when in fact it is a sort of reflex machine, and an especially refined one, able to imitate the moral and other subtle feelings of the genuine human being (see Cleckley 1964, p. 406). The psychopath has no intellectual difficulty in understanding the game rules of human interaction, but he clearly lacks the emotions that correspond to them. In Cleckley's allegorical term he suffers from semantic dementia; that is, he is not able to comprehend central human experiences with any degree of depth, though he pretends to understand.

The psychopath we are here presented with is in his clinical coloration much like that of Karpman, and Partridge's true sociopath, and the moral idiot or morally insane of the late 18th century, or the born criminal. Of the relationship of this group to the official category Psychopathic Personality Cleckley writes (1947, p. 395):

> The term (psychopathic personality or psychopath) is seldom if ever used to denote all that one finds listed in that category since it strongly implies a restriction to only one of these several and quite different types. If a psychiatrist, in speaking to another about a patient, uses the term *psychopath*, there is seldom any misunderstanding as to the sort of patient in question. How such patients will behave is common knowledge to all who have known them. Few psychiatrists, informally and among themselves, ever use *psychopath* if they refer to patients whose personality difficulties are predominantly schizoid or cyclothymic or whose problems consist primarily in a well defined sexual deviation such as homoeroticism. What the average psychiatrist means by *psychopath* is a remarkably definite type of patient who, at the clinical level of behavior, can be readily distinguished from all the other types listed with them, presumably as similar, or at least as definitely allied, in our technical scheme for classification of mental disorders.[45]

[44] Larsen (1975 p. 86) would even compare Cleckley's role in American psychiatry with Schneider's in European. If the popularity of Cleckley's psychopathy concept on a descriptive level is considered the comparison is justified. Cf. also McCord & McCord 1964, p. viii.

[45] It is likely that Cleckley has underestimated the variegated nature of the psychopathy concept within American psychiatry (cf. Preu's views section 6.2.5, above). Karpman (1947/48 p. 524) has an opinion contrary to Cleckley's and complains over the fact that it is only a minority—among them Maughs (cf. chap. 1, note 8)—that uses the diagnosis psychopathic personality in its limited sense. Neither this is a correct description, as far as I can determine, of the situation at the middle of the 1940s. It is not difficult to find literature from the period, in which "psychopathy" is viewed in about the same way as Karpman and Cleckley describe the "syndrome". One example is the known research pair Sheldon and Eleanor Glueck. In a footnote to the foreword to Lindner's work, mentioned above, they even write (Lindner 1944, p. ix): "The psychopathic personality most nearly approaches the 'born criminal type' described so minutely by Lombroso".

Cleckley's treatment of the subject is distinctly clinical-descriptive. He has attained an intuitive idea of the significant aspects of psychopathy and it is this he wishes to convey to the reader, in part with the aid of case descriptions. Under sixteen different points he describes those traits that he considers to be distinctive for psychopathic disorder. These are somewhat unsystematic and partially overlap each other. Nor are the descriptions contained in any specific theory, even if the author naturally has opinions on the origin of psychopathy, its susceptibility to treatment, etc.

In the more circumscribed presentation of "psychopathic states" in the *American Handbook of Psychiatry* (1959) Cleckley summarizes the characteristics of the psychopath in fewer points, fourteen. In the survey of his viewpoints below, we shall follow the latter version (ibid. pp. 581 ff.):

1) "Unexplained failure". Normally there is no disturbance in intellectual development. The psychopath is normally, often even highly gifted. Despite this he regularly fails in what he attempts.

2) "Undisturbed technical intelligence". No sign of psychosis such as hallucination or delusions is present.

3) "Absence of neurotic anxiety". The psychopath does not suffer from anxiety, phobias, obsessive thoughts or other psychoneurotic symptoms. He is often calm and balanced in situations where ordinary persons become tense and nervous.

4) "Persistent and inadequately motivated antisocial behavior". From the psychopath's behavior the conclusion could be drawn that he is ruled by strong, overpowering impulses, or that the economic gain from his criminality is great. However, closer study reveals that the actions of the psychopath do not depend on either exceptionally strong impulses nor economic motives. The behavior often seems to depend on coincidence and personal whim. Carefully planned, long-range actions, whether they are social or criminal, are alien to him.

5) "Irresponsibility". Despite a surface charm and confidence-embuing impression given by the psychopath, his actions are often examples of extreme irresponsibility: "He will, eventually, ignore even the gravest of responsibilities and most often for the most trivial of reasons" (ibid. p. 581).

6) "Peculiar inability to distinguish between truth and falsehood". Of course the psychopath can with his good intelligence distinguish between true and false. On the other hand he seems to attach little importance to that distinction. He can for example swear and make a solemn promise which shortly thereafter he will not even attempt to keep. He lies notably often, even though he is in no way forced to do so.

7) "Inability to accept blame". The psychopath will often deny having committed a crime, though the evidence is overwhelming. Suddenly he will "throw in the towel" and calmly and with no sign of feeling, shame or regret admit what he has done. Immediately thereafter he may, however, speak in an eloquent and engaged manner of his regret and resolution to better himself. One would believe

him but for the fact that his life constantly gives the lie to his words.

8) "Failure to learn by experience". Despite the psychopath's ability to reason logically at an abstract level, he shows "extremely defective judgement when he becomes an active participant in the affairs of life" (ibid. p. 582). Time after time he finds himself in similar situations, but never learns how to avoid them.

9) "Incapacity for love". The psychopath has no difficulty in forming superficial relationships. On the other hand, his behavior shows an inability to experience lasting love and empathy. When he finds himself in trouble he often deserts the one he purports to love, and loyalty as a reality is something foreign to him.

10) "Inappropriate or fantastic reactions to alcohol". According to Cleckley a careful distinction should be made between alcoholism and psychopathy. Many psychopaths exhibit no tendency to misuse spirits, others periodically devote themselves to uninhibited drinking without therefore being alcoholics in a medical sense. Characteristic for the psychopath is that in a drunken condition he will often carry out bizarre actions, and consequently is less predictable than the ordinary alcoholic.

11) "Lack of insight". It may be concluded from the psychopath's description of himself and his situation that he possesses a good degree of insight, but to judge from his actions this is hardly more than "a clever mimicry of insight" (ibid. p. 582). He lacks to a high degree the ability to see himself as others see him and he is amazed when those whom he has failed doubt his honest intentions.

12) "Shallow and impersonal responses to sexual life". With male as well as female psychopaths the sexual life is often promiscuous. However, Cleckley doubts that this depends on abnormally strong drives. Rather it is the inhibitory functions that are weak. The sexual life is for these people "impersonal, emotionally trivial, and poorly integrated with their alleged goals" (ibid. p. 583).

13) "Suicide rarely carried out". The psychopath as described by Cleckley very rarely commits suicide. On the other hand he sometimes threatens to do so. He may even make demonstrative but harmless attempts at suicide in order to reach a certain result. However, any real desire to take his own life is foreign to him, since he does not experience any deeper feeling of regret or failure.

14) "Persistent pattern of self-defeat". The psychopath is often capable of following a plan during certain periods of his life, devoting himself to gaining an education or carrying out a job. Notable, however, is the rapidity and ease with which he abandons his plans and ruins what he had carefully built up during his ambitious period: "Sometimes these people after periods of excellent adjustment and apparent contentment seem deliberately to go out of their way to bring disaster upon themselves" (ibid. p. 583).

All of the behavior that Cleckley attempts to summarize in the above points—"the intricate pattern of gratuitous folly, nonsensical failure, and unprovoked social aggression repeated over and over"—is so remarkable, that he is forced to ask himself: "If this is sanity can it be more than sanity in the name only?" (ibid. p. 583).

Cleckley has no decided ideas on the etiology of psychopathy, but he suspects that it has a primarily organic basis. He explains that he knows of far too many psychopaths who have grown up in—insofar as he has been able to determine—normal families to believe in a purely psychodynamic explanation for their behavioral disturbances. Accordingly he is also skeptical over the possibilities of any lasting "cure".

6.2.9 Continuing Developments in America

It is impossible in the present work to even do a semblance of justice to the psychopathy literature that has been published in America since the 1940s. Nor is this the proper place for such an overview.[46] McCord & McCord (1964, p. vii) state that between 1940 and 1955, 171 scientific articles in the area appeared. The figure is probably only for English-language articles. The flood of books and articles on psychopathy has continued to increase in volume since that time.

A review of some of the literature confirms the view that the above described tendency to limit the psychopathy concept to intend a clinically identifiable core group continued. Few American authors have in recent years put forth a significantly different clinical picture of psychopathy than that which for example Cleckley described. However, regarding interpretations of this behavioral disturbance opinions are divided. Here below I will mention only a few of the more prominent authors in the area.

In 1956 an important contribution to the psychopathy debate was published, William and Joan McCord's *Psychopathy and Delinquency*. It appeared in 1964 in a revised and expanded version called *The Psychopath. An Essay on the Criminal Mind*. The authors are convinced that psychopathy, in its limited sense, is a relatively uniform syndrome, and they refer with irony to those researchers who consider the concept in question to be superfluous.[47]

The McCords recommend a dimensional perspective on psychopathy and they see no reason to set up an absolute line between psychopathy and less serious behavioral disorders. Psychopathy is seen as lying farthest out on a hypothesized scale of so-called behavior or character disorders (see McCord & McCord 1964, p. 19).[48] As a consequence of this reasoning, the diagnosis psychopathy is

[46] Maughs (1949, 1955) has in a series of abstracts compiled the English-language literature in the area released between 1940 and 1954. He groups the material under the rubrics "The Organic Approach", "The Descriptive Approach", "The Empirical Approach", and "The Psychodynamic Approach". A comprehensive bibliography on literature dealing with psychopathy has also been compiled by Hare & Hare (1967).

[47] Here they cite the Swede Olof Kinberg as an example; however, as we touched on earlier, he worked with the wide German notions of psychopathy (cf. chap. 5, notes 51 and 56).

[48] A brief discussion of the dimensional vs. the classificatory or typological view within psychopathology, especially concerning psychopathy, can be found in section 7.4, and notes 14, 15 (chap. 7).

reserved for extreme cases. Two important traits should be present here: "guiltlessness" and "lovelessness" (ibid. p. 17). The McCords find these to stand forth as lacks *par preference* in the psychopath's mental equipment, lacks that especially characterize him in relation to emotionally normal persons.

The two researchers describe the psychopath under such headings as "The psychopath is asocial", "The psychopath is driven by uncontrolled desires", "The psychopath is highly impulsive", "The psychopath is aggressive", "The psychopath feels little guilt", "The psychopath has a warped capacity for love". In the phrases we recognize much of Karpman's and Cleckley's psychopath.

These personality traits add up to give us the picture of a badly maladjusted personality whose behavior often places him in conflict with society. He is a self-centered person who seeks immediate sensual experience, and lacks any continuity—the present is torn loose from its relationship to the past and the future. Thus his actions are unplanned and arbitrary. He is also aggressive, for he has not learned how to deal with frustrations in a socially acceptable fashion. Above all he lacks feelings of guilt and the ability to love other people.

But the McCords have not only—or even primarily—attempted to refine the clinical description of psychopathy. They set up a theory of its causes and also evaluate the methods of treatment that have been tried. It is clear that the "hereditarians" as well as the neurologists and "environmentalists" have contributed to our knowledge of the causes of psychopathy. The authors find that the many investigations, especially during the 1930s, hardly gave any proof that heredity is an important factor in the context. Neurological facts indicate, however, that brain lesion, especially to the frontal lobes and hypothalamus, often leads to aggressiveness and asocial behavior. Finally, environmental researchers have shown convincingly the destructive significance of early emotional rejection.

However, not all children treated lovelessly develop into psychopaths; there must be other contributing factors. It is certainly possible to find a correlation between the degree of rejection, and how clearly marked the psychopathic characteristics are.

As the authors see it, rejection is, however, scarcely sufficient as an etiological factor for psychopathy; neurological lesions sometimes also contribute here. They summarize their "neuro-social" theory of psychopathy with the following points (ibid. p. 85):

1) Severe rejection, by itself, can cause psychopathy;
2) Mild rejection, in combination with damage to the brain area which normally inhibits behavior, causes psychopathy;
3) Mild rejection, in the absence of neural disorder, can result in psychopathy if certain other influences in the environment fail to provide alternatives.

How do the McCords view prospects for changing the psychopath? Working with a thorough evaluation of the therapeutic results at the Wiltwyck School for Boys in New York, they are optimistic, for that showed astonishingly good treatment results, especially in the cases of behavioral disturbance and psychopathy.

They appear to be convinced that with "total-push" methods such as the milieu therapy at Wiltwyck it is possible to achieve lasting change, at least in psychopathic children and youth. Naturally they are less hopeful about adult psychopaths.

A somewhat more comprehensive psychopathy concept is presented by the psychiatrist Silvano Arieti. Like Cleckley he dislikes the official nomenclature regarding behavioral disorders[49] and claims that it is necessary to distinguish between personality deviations "which appear as secondary manifestations in practically all psychiatric conditions from the syndromes in which they constitute the basic pathology" (Arieti 1963, p. 301).

Like Karpman he speaks of symptomatic and idiopathic psychopaths or of pseudo- and true psychopaths.[50] In the pseudo-psychopathic group we find for example psychoneurotics and character neurotics showing asocial behavior. Here too are post-psychotic patients who have reintegrated only at what seems to be a psychopathic level. With a true psychopath Arieti means (ibid. p. 301):

> A person of at least average and often superior intelligence, who is given to recurring acts of inadequately motivated antisocial behavior, who seems irresponsible, lacking anxiety or guilt over his past and future actions, and who seems unable to learn from experience about the unfeasibility of his antisocial behavior.

Arieti believes that this group is easily recognized by all psychiatrists and answers to the official category Sociopathic Personality: Antisocial Reaction. He considers it possible to distinguish four subgroups: (a) the simple psychopath; (b) the complex psychopath; (c) the dysocial psychopath; and (d) the paranoiac psychopath.

Central in the simple psychopath's mode of functioning is the strong urge toward immediate need gratification—independent of what other people may think. If his need is not filled he experiences a seemingly unendurable frustration. Future pleasure sensations have no real meaning for the psychopath. He lives emotionally in the immediate present and completely disregards tomorrow.

The neurotic reacts quite differently with his anxiety—and here we have an important differential diagnostic criterion distinguishing neurosis and psychopathy. The basis of neurotic anxiety is not the fear of an immediately expected torment but terror of sensed future dangers. Arieti calls this anxiety "long-circuited". The psychopath can also experience a sort of anxiety, but it is "a short-circuited anxiety, which may be called tension or discomfort" (ibid. p. 303). The thought of future punishment, for example, is not followed by any stronger feelings in the psychopath, and consequently have little influence of his actions.

[49] However, Arieti dissociates himself from Cleckley's opinion that the psychopath suffers from a sort of psychosis.

[50] Arieti's true psychopath does not indicate, as will be clear below, exactly the same hard core group as Karpman would encircle with his expression idiopathic or genuine psychopathy.

Arieti also traces the psychopath's lack of loyalty, whether to a person, group or code, to the underlying short-circuit mechanism. But why do certain individuals resort to this method? Constitutional and neurological explanations have proven inadequate, even if certain brain lesions may lead to a change of personality in a psychopathic direction. As Arieti sees it, the only remaining alternative is to explain the genesis of psychopathy in psychodynamic terms.

The other psychopathic subgroups also function basically according to the above-described pattern but have additional specific characteristics. The complex psychopath has a useful resource in his intelligence and relatively good ego strenght. It is thus possible for him to act in a more long-range fashion, but basically he employs these "long-circuited mechanisms - - - in the service of short-circuited ones" (ibid. p. 307). And moral doubts do not prevent pleasure experiences in this case either. The only difference between simple and complex psychopaths is therefore that the latter function at a much higher level. In this group we find for example the professional bankrobber and certain unscrupulous politicians.

In addition to psychopathic traits the dysocial psychopath also has a subcultural identification. Many researchers prefer not to count him among the psychopaths at all. This can also be said of the paranoid psychopath, who is somewhere on the line between true psychopathy and paranoia. The classical example of a paranoid psychopath is, according to Arieti, Adolf Hilter.

6.3 Modern Anglo-Saxon Theories on Psychopathy

The number of theories on the nature and causes of psychopathy has with the passage of time been considerable. The last half-century has seen everything from pronounced environmental theories to completely organic explanatory models. Samples of the former we see especially in section 6.2.6, above, and we have also treated organically based theories, e.g. the idea of psychopathy as a hereditary phenomenon (cf. chaps. 3, 4, 5).

Much current research is built on the assumption that there is a physiological base for psychopathic behavior. With the latter is meant the behavior cluster or syndrome that has been circumscribed by clinicians such as Karpman and Cleckley. What is primarily sought is to experimentally establish correlations between physiological activity and psychopathic behavior.

Several such correlations have been shown. They do not say anything about causes but may hopefully lead to research which could contribute to explaining the etiology of psychopathy. Correlations of the above-named kind might also point to diagnostic methods complementary to the clinical, and thereby contribute to a more exact assessment of psychopathy than what is now possible. A good summary description of this research has been done by Hare (1970) and a newly published contribution in the same genre is that of Hare & Schalling (1977).

Ever since the 1940s certain researchers have hoped that the elec-

troencephalogram or EEG,[51] as it is commonly called, would prove to be such a variable as might contribute to a more objective diagnosing of psychopathy—this because investigations have proved a relationship between psychopathy and EEG abnormalities, especially so-called immature EEGs. This latter means that the abnormal records exhibit similarities with the ones usually found in children. This has led to the theory that the defective social behavior which is a mark of the psychopathy, may be based on a maturational retardation of the central nervous system. Other theories have also been put forth.[52]

Other researchers have attempted to relate psychopathy to the functions of the autonomic nervous system. Experimental data show that psychopathic individuals in general have a lower autonomic activity than others. This is in line with the view of the psychopath as a person with low tendency to tension, that is, he does not worry himself and does not suffer from feelings of guilt.

The most characteristic of psychopathy is, according to Quay (1965/66, p. 180), "the impulsivity and the lack of even minimal tolerance fore sameness". These he sees as the primary and distinctive features of the disorder. He has hypothesized that they are related to a lowered activation level in the brain, which leads to a chronic stimulation-seeking behavior. The psychopath needs in other words more "sensory input" than other people in order to maintain an experientially satisfactory level of arousal.[53]

Hans Eysenck, psychology professor at London University, has in recent years also related his personality dimension extraversion to the activation level in the reticular system and cortex. He considers that the extravert has a low, and the introvert a high activation level. Eysenck's second personality dimension, neuroticism, which means something like emotionality, has to do with a lability of the autonomous nervous system. Neurotics are, according to Eysenck high on this scale, but, what is notable, so are psychopaths, who could thus be seen as neurotic extraverts. Hare (1970) and other researchers find this incompatible with their own theories and experimental findings. According to them, the psychopath does not exhibit autonomous lability and is consequently a stable extravert to put

[51] The electroencephalogram (EEG) is those curves obtained with a measurement of the brain's electrical activity. They express primarily the activity in the cortex, but due to the network of connections between it and the basal sections of the brain, the EEG reflects the activity of the brain generally.

[52] Easily understandable summaries of the research concerned with the EEG of the psychopath have been done by Fabisch (1966) and Hare (1970).

[53] The concept activation or arousal "can be defined as a dimension representing the physiological and psychological state of an organism", writes Hare (1970, pp. 58 f.), and he continues: "The low end of the dimension is characterized by deep sleep, complete loss of awareness and a low level of physiological activity. As arousal increases, the individual's awareness of the environment and his behavioral efficiency also increases, but only up to a point—at very high levels of arousal awareness and efficiency tend to break down". It may then be surmised that there is an optimal arousal level which is pleasant to the individual and relevant for the immediate situation. Therefore the organism continuously strives to reestablish and maintain this optimal level.

it into Eysenck's words. His so-called psychopath is considered by Hare to be basically a neurotic.

Some researchers have in recent years expressed the hope that newly made discoveries of anomalies in the sex chromosomes may explain certain psychopathies. This is so because it has been found that two or three per cent of those males who commit violent crimes have XXY chromosome complements instead of the normal XY; that is to say, they have a double number of the chromosome determining male sex. Since the disturbance is especially uncommon in the normal population, the assumption that it may have a relationship with aggressive behavior is reasonable. However, nothing is known how this connection is to be explained more exactly (see Hare 1970, p. 72).

Attempts have also been made to explain psychopathic behavior from the point of view of learning theories. Eysenck (1964) has presented the hypothesis that the psychopath as an extravert easily builds up cortical inhibitory potentials; in other words he is difficult to condition. Since social behavior in Eysenck's opinion depends on conditioning, the consequence is that many psychopaths lack the ability to conduct themselves according to social norms: they cannot elicit the proper conditioned responses.

Other researchers subscribe to Mowrer's theory of avoidance learning. In broad outline, its content is as follows. Through mistakes, the child learns that certain actions lead to "punishment" (negative reinforcement). For example, to put one's finger into a flame will cause pain. The mere sight of a flame will later be sufficient—due to the conditioning that have been established—to cause fear in the child. This can, however, be reduced if the child avoids flame. When he does so, he is "rewarded" (positive reinforcement), since the unpleasant sensation (fear) disappears, and therefore the tendency of the child to go on avoiding flame will be reinforced. This theory is easily shifted to the area of social learning. Important for our context is that psychopaths have shown themselves to have a low capacity for fear conditioning. The anticipatory anxiety or fear that keeps most persons from even thinking about forbidden acts is weak in the psychopath, or nonexistant.[54]

[54] Mowrer's theory shows clear parallels with the psychoanalytic point of view on these questions. He has in fact been quite interested in psychoanalytic theory, believing that "the most important and exciting future advances in the understanding of personality and in psychotherapy will come from the mutual modification and blending of learning theory and psychoanalysis" (Mowrer 1948, p. 571).

Freud speaks of superego anxiety (cf. Mowrer: conditioned fear), that is, qualms of conscience and guilt feelings that arise when the id and the ego consider satisfying impulses that are unacceptable to the superego. This moral anxiety is unpleasant, so that any activity which reduces it gives satisfaction (Mowrer: positive reinforcement). As Freud sees it, we thereby avoid socially forbidden actions (see Freud 1973, pp. 386 ff.).

What then is the condition of the psychopath? His superego is poorly developed, that is, he has not introjected the commands and prohibitions of his parents and society to a satisfactory degree (Mowrer: weak fear conditioning). Therefore an insufficient superego anxiety is generated; he is not prevented from carrying out socially forbidden acts.

Finally, psychopathy has been considered from the point of view of social psychology. Gough (1947/48) for example starts with G.H. Mead's idea of the self, which grows in tact with the ability of the individual to see himself with the eyes of others or—as Mead phrases it—"to take the role of the other". Gough writes on this (p. 363):

> First of all, the basis for the individual sociality is social interaction, and this interaction is effective in so far as the individual can look upon himself as an object or can assume various roles. This role-taking ability provides a technique for self-understanding and self-control. Learned prohibitions - - - may be observed by "telling one's self" not to behave in a certain way. Or speech may be editorially "reviewed" as it is emitted, and the inadmissible deleted. Role-playing, or putting one's self in another's position, enables a person to predict the other's behavior. Finally, role-playing ability makes one sensitive in advance to reactions of others; such prescience may then deter or modify the unexpressed action.

Gough says that the psychopath is "pathologically deficient in role-playing activities" (p. 363). He thus has difficulties in predicting the consequences of his actions, since he cannot judge them from the point of view of others. "Social" feelings such as embarrasment, shame, and loyalty are foreign to him, for the same reason. If the behavior of psychopaths is interpreted in this way, the most adequate therapy is according to Gough roll training, but of course of a different kind than was employed in neurosis therapy.

6.4 Summary

In Britain there was much discussion of the legally important term moral imbecility during the first three decades of the twentieth century. A debated question was whether "moral imbecility" should only indicate such cases that also exhibited intellectual retardation. Tregold, writing on "mental deficiency" and one of the experts preparing the Mental Deficiency Act (1913), was of that opinion. He claimed that in most cases moral imbecility is associated with inferior intellectual capacity. This corresponds rather poorly with his attempt to explain the moral disturbance with the aid of the old Scottish psychology, which maintained the view of relatively independant mental faculties, including a moral one.

Tregold's old-fashioned point of view was sharply criticised by the psychologist Burt, who definitely rejected the concept moral imbecility at a symposium in 1926. Burt reviews the results given by his own investigation, which shows that those persons who have received the diagnosis moral imbecility make up an extremely heterogeneous group—not least in question of intelligence. As a result of massive criticism the Mental Deficiency Act was changed in 1927, and the term "moral defectiveness" was substituted for "moral imbecility".

In 1927 the first edition of Henderson & Gillespie's widely distributed psychiatry text was published. Through the various editions it is possible to follow the development of Henderson's ideas on psychopathy. Up to and including the

fourth edition (1936) it is primarily the current American view that is reflected. In 1939, however, Henderson presents an idea that is partly different. He seems to espouse a constitutionally anchored psychopathy concept—a sort of disposition for mental illness and asocial development. But "constitution" is not the same for him as "determined by heredity". At times the psychopathic condition manifests itself in more specific syndromes. Henderson explains that he wishes to avoid unnecessary pigeon holing, and sets up only three categories which he feels is enough: the predominantly inadequate, the predominantly aggressive and, surprisingly, the predominantly creative. The last-named is probably inspired by the *dégénéré supérieur* of French psychiatry. Henderson's psychopathy concept gained a certain popularity and was for a time used in clinical contexts parallel to the legal term moral defectiveness.

Curran & Mallinson (1944) state that the psychopathy diagnosis has obviously been used to designate three partly different groups, the vulnerable, the abnormal or unusual and the asocial. They have reviewed international literature but this of course also includes British material.

Anderson (1962) considers that Henderson has had a certain influence, but is of the opinion that the legal concept "moral defectiveness" has had too great an influence on the view of psychopathy in Britain. When the concept "psychopathic disorder" was introduced into the Mental Health Act of 1959, thus replacing "moral defectiveness", in Anderson's eyes this was only a change of terms.

Anderson wishes to introduce Schneider's psychopathy concept, and, to a certain extent, so do Mayer-Gross et al. This is expressed in their treatment of the relationship between psychopathy and neurosis, but their point of view has had only limited success.

Craft (1966b) finds that the dominating view among British experts in the area is that psychopathy makes up a clinically identifiable syndrome. Its most important characteristics are "a lack of feeling quality to other humans", or "lovelessness" and "a liability to act on impulse" (p. 5). Other characteristics that may be deduced from the first two are aggressiveness, lack of shame and feelings of regret, inability to benefit from experience and properly employ their natural gifts.

American psychiatry took a great step forward through the inventive work of the Swiss immigrant Adolf Meyer. Part of his contribution was his presentation of many fruitful ideas from European Continental psychiatry, and he also transformed certain of these ideas in accordance with his own view of the problems. His early psychopathy concept, constitutional inferiority, formulated in 1905, instituted a miscellaneous remainder of constitutional mental and physical anomalies, which it was not possible to place in other psychiatric classes. Thus he defined his psychopathy concept in a different manner than contemporary Germans. The concept did not include the so-called neuroses (hysteria, neurasthenia, psychasthenia, epilepsy), and this had consequences for future development. It probably simplified the acceptance of the psychodynamic view of neuroses, which

would as early as the close of the 1920s dominate among American psychiatrists.

Oberndorf (1912) and Healy (1915) also use Meyer's concept and speak of psychic constitutional inferiority, while Carpas represents another opinion based on a traditional division of the mind into cognition, will, and emotion.

In 1923 Karpman took the initiative in setting up a symposium on psychopathy. The contributions were disparate, but even at this early date a tendency can be noted among the participants to encircle a clinical syndrome that is distinct from psychoneuroses, partly through characteristics such as egocentricity, aggressiveness, insensitivity, etc. The psychopath is not considered suitable for psychoanalytic treatment, since he does not in fact wish to become any different than he is.

Towards the end of the 1920s Partridge, with an ambitious research project, attempted to clarify the vague psychopathy diagnosis. Since the concept appears to be very heterogeneous, he proposes that one manifestation of psychopathy be focused on: asociality and criminality. Partridge thus recommends a sociologically based concept, sociopathy, without any etiological connotations. Within this broad category he distinguishes a hardcore group called essential sociopaths with a deeply rooted antisocial motivation.

Partridge's concept was met by some doubt, yet still influenced the American view on psychopathy. His term was given official status during the 1950s, when the collective term sociopathic personality was promoted.

Preu attempts in 1944 to summarize the content of the psychopathy concept in America. He finds two criteria important if the diagnosis is to be considered: social maladjustment and difficulty in placing the observed deviation within any of the other psychiatric classes. Preu is rather critical of the psychopathy concept—"a diagnosis of convenience arrived at by a process of exclusion" (p. 936).

Psychoanalysts came in relatively early contact with asocial behavior. As early as 1915 Freud assumed that criminality could be the expression of strong feelings of unexplained guilt. Aichhorn, who did practical work with asocial children and youth, also made theoretical contributions through distinguishing between the neurotic delinquent and the more genuin criminal with great difficulty in being emotionally bound to the warder.

At this time Reich was working with the so-called impulse-ridden characters, and Abraham (1925) writes of a fraud, whom he had encountered while acting as a military physician. He interprets his behavior as an expression of an unsolved oedipal conflict, which forced the man to remain at a narcissistic stage.

At the end of the 1920s Alexander attempted to summarize the presented points of view. He explains certain asocial behavior as expression of a neurotic conflict which is acted out instead of being expressed as neurotic symptoms. Consequently the behavior should be seen as symptom of a so-called neurotic character. Among criminals there are many who are driven to commit crimes by their unconscious conflicts.

Wittels (1937) is of another opinion. He sees the psychopath—especially the

promiscuous—as an individual reminding of the classical renaissance figure, fearing nothing—least of all himself. Thus he has the ability to hedonistically enjoy everything, both his masculine and feminine sides, without qualms of conscience or repressions. This category is said to be fixated in Freud's phallic phase.

After hypnoanalysis of a psychopath, Lindner (1944) draws the conclusion that he suffers from a deep hatred of his father and thus has been unable to solve his oedipal conflict. This has prevented his conscience—the introjected father—from developing.

Friedlander (1947) describes the seriously criminal as narcissistic and emotionally infantile. Behind this she finds a primary fixation in the anal-sadistic phase.

In 1952 Karpman attempted to summarize the contribution of psychoanalysts in respect to psychopathy. He finds them to be in clear disagreement—at least regarding the psychosexual phase, to which the psychopath's fixation is primarily placed. What Karpman does not note is the general agreement among psychoanalysts in general when it comes to the question of the socialization process, the normal as well as the deviate. Here the psychopath is seen as a personality with an inadequately developed superego. He is considered by most as very difficult to treat psychoanalytically, for the analysis seldom if ever reaches such depth that transference occurs.

In a number of papers published during the 1940s Karpman clarified his own view on psychopathy. That which is generally known by that name should according to him be divided into symptomatic and idiopathic or true psychopathy. The latter condition is characterized by the fact that it is not possible to find a psychodynamic explanation. Thus it seems to depend on a deficit in mental equipment. Many researchers have expressed doubts about this hypothesis, but accept the clinical picture of the psychopath as Karpman sketches it.

Cleckley has through his suggestive depiction of the psychopath come to significantly influence developments in America. He also describes him as being inhuman in certain respects, foreign to the genuine moral and other subtle emotions. For him the psychopath is a reflex machine, a deeply disturbed person suffering from "semantic dementia".

In recent years many American researchers have been of that opinion that these descriptions of psychopathy encircle a central clinical syndrome. This can be seen for example with the McCords, who believe they have found the psychopath to be characterized by two basic qualities, guiltlessness and lovelessness. From these derive other characteristics. They prefer a dimensional perspective on psychopathy to the traditional typological or classificational and advocate their own "neuro-social" theory concerning the origin of psychopathy, that is, they allow for both neurological and social psychological factors. As regards treatment of young psychopaths, they are relatively optimistic.

Arieti (1963) attempts to distinguish between neurotic and psychopathic behavior with the aid of the expressions long-circuited and short-circuited anxiety.

The latter way of reacting, which sets its mark on the actions of the psychopath, originates in his need for immediate gratification. The anxiety of the neurotic, on the other hand, is an expectation anxiety, a fear of suspected future dangers. It is so to say long term.

The behavior cluster or syndrome that has crystallized out during the past 40 or 50 years in American psychiatry, and has developed in its own fashion in Great Britain, now seems to have been accepted by most modern researchers on psychopathy. They are now occupied primarily with attempts to map out the nature and causes of this syndrome.

In that connection great differences stand out as regards views and research approaches. A large part of the actual research on psychopathy aims at connecting psychopathic behavior with physiological and psychophysiological variables. It is in this area that we find research on genetic defects in certain psychopaths. Here also is the investigations of the EEG of psychopathic individuals, their autonomic nerve functions and level of brain activity (e.g. Quay; Hare; Schalling). Other researchers have preferred to interpret the psychopath's mode of reaction in terms of learning theory (e.g. Eysenck; Mowrer), or worked with social psychological concepts (Gough). Somatic and environmentally-oriented theories stand, now as earlier in the history of the psychopathy concepts, side by side.

7 Summary and Discussion

7.1 Introduction

The primary aim of the present dissertation has been to show the historical course of the discussion on psychopathy.[1] The investigation has been relatively broad, as the relevant phenomena have been shown to be historically and currently intimately related to psychiatry as a whole, which in turn reflects more general currents of thought in each period. For example, at the beginning of the 19th century we find within psychiatry ideas on the nature of man which are derived from the philosophy of Enlightenment, whereas, at the end of the century, when physicians were influenced by evolutionism and positivism, the psychiatrist's view of man is biological and materialistic.

The present chapter is not intended to be a detailed resumé of the dissertation; for this the reader is referred to the summaries concluding chapters 2–6. Instead this final chapter presents the general lines of development and a broad outline of tendencies (see section 7.2, below).

The emphasis of my research objectives on concepts and concept analysis has motivated a closer study of concept formation within psychopathology, the utilization of psychodiagnostic concepts and the accompanying risks, etc. Facts and positions on these questions are given below in section 7.3.

Use has been made in the dissertation of such traditional psychiatric terms as psychopathology, symptom, syndrome, etc. These have provided an obvious frame of reference for the majority of writers who have in the past written on psychopathy and closely related phenomena. Hence it seems natural to use traditional psychiatric terms when presenting a historical description of these writers' viewpoints. Exception has been made primarily in the interest of greater clarity or for reasons of style. My own point of view on the current psychopathy concept is given mainly in section 7.4 below.

7.2 Some General Tendencies and Lines of Development

At an early stage in my research it became clear that there existed not one concept of psychopathy but many. From the disposition of the dissertation it can be seen that it is possible to trace three major intellectual traditions in the history of the psychopathy concept: an original French, a later Continental-European and an

[1] A more detailed account of the task I have set myself is to be found in chap. 1.

Anglo-Saxon. We shall here concentrate on the latter two, as both are of current significance today.[2]

With the publication of Morel's work (1857, 1860; cf. section 3.2.2) a line of thought in European psychiatry was initiated from which the psychopathy notions of the Germans eventually developed. They work with collective concepts on a level comparable to what we now call psychosis. That is to say, no attempt is made to distinguish a simple syndrome or behavior cluster, but instead a heterogeneous group of anomalies are designated. If one follows Schneider (cf. section 5.2.2), whose theories in the area have dominated for many years, it is a question of hereditary deviations from the normal in the areas of emotions, volition and impulse.[3] The deviations, which can express themselves in a variety of ways, are not considered to have the character of disease but are seen as relatively permanent variations in personality development (abnormal personalities). However, those mental disturbances which are characterized by previously demonstrated or merely assumed organic disease processes or lesions in the neurological substrata, are noted as mental diseases.[4]

[2] In his historical overview of the psychopathy concept Pichot (1977) has described the three following lines of development: (a) The descriptive moral insanity concept, based primarily upon asocial behavior. This is a concept having its origin in early French psychiatry, but finding classic expression with the Englishman Prichard (1835). (b) The concept of degeneration which can encompass antisocial behavior, but refers above all to a special nervous vulnerability or fragility. (c) The German psychopathy concept, the definition of which is not determined by social criteria.

It would seem that Pichot has derived his first line of development from the same mistaken idea of Prichard's concept as has misled psychiatric authorities since the 1800s (cf. sections 2.3 and 2.6.1). The other two lines of development can of course be handled separately as Pichot does here. I have, however, preferred to consider the French and German developments in the area as a continuous line, for this illustrates the development of the German concepts of psychopathy from the degeneration theory, especially the notion of polymorphic heredity (cf. chap. 3).

[3] During the first decades of this century a discussion took place which had its origins in the 18th century psychological debate on the indivisibility of the mind. It was concerned with what aspects of personality that should be included in the concept psychopathic personality. Wilmanns and Gruhle for example (cf. section 5.1.4) considered that even intelligence defects should be counted. However, there was agreement that these should be treated separately from the affective-conative side of the personality, which after all seemed to function to a certain extent independent of the intellectual sphere. For the historical aspects of this question see mainly chap. 2 and also section 6.1.1.

When experimental psychology began to show an interest in intelligence measurement, the intellectual aspect of the mind became the domain of a new professional group, theoretically as well as practically active psychologists. Simplifying somewhat, it can be said that via the intelligence tests these have penetrated further and further into the psychiatrist's traditional field of activity—a development which is resisted by organically-oriented psychiatrists.

[4] Apart from the position advocated by Kretschmer and his associates, in the German-speaking nations a distinct line was drawn between psychosis on the one hand and psychopathy and neurosis on the other. There was a tendency to see neurotic manifestations as being in themselves adequate reactions to environmental stimuli in individuals with special characters (abnormal personalities). Hence with asthenic psychopaths it was natural to find neuroses characterized by anxiety, with other psychopaths hysterical neuroses, etc. (cf. section 5.2.3). However, Schneider's division of the psychopaths into *suffering* and *disturbing* abnormal personalities proves in practice to partly coincide with the Anglo-Saxon distinction between what is there called psychopaths and neurotics.

The theory of degeneration which came from France laid the foundation for the system of grouping mental deviations which began with Koch and his collective concept *psychopathische Minderwertigkeiten* (cf. section 5.1.1). When this approach finally lost its appeal it was replaced by the notion of a statistic abnormality.

The situation was different in Britain and America. Maudsley (cf. section 4.4) who was admittedly an influential psychiatrist, was strongly influenced by the degeneration hypotheses, but besides him were other equally influential physicians such as D. Hack Tuke (cf. section 4.4) with partially different frames of reference. Thus many British psychiatrists tended to maintain a traditional faculty psychology-based perspective. Consequently the debate in this area tended, for many years after the turn of the century, to be concerned with the moral imbecility concept, which was an offspring in direct descent from the later, narrower moral insanity concept (cf. esp. chap. 4).

The position taken by Adolf Meyer (cf. section 6.2.1) against the doctrines of degeneracy and in favor of a dynamic point of view, one which did not ignore hereditary factors yet gave priority to the psychological and social causes of mental disturbance, came to exercise a decisive influence in American psychiatry. The interest in clinical demarcations and classifications diminished in favor of an attempt to understand psychopathological phenomena as reactions to the total biosocial situation of the individual.

Naturally this approach also had consequences for views on psychopathy. In traditional German psychiatry the conviction was prevalent that this disturbance was primarily hereditary. The diagnosis psychopathy was only used if the patients' deviations were believed to have a hereditary basis. In America on the other hand Meyer's theories early drew attention to the role of environmental factors, an attention which grew still sharper with the advances made by psychoanalytic thinking among American psychiatrists during the 1920s. The diverse opinions on the etiology of psychopathy resulted in the diagnosis eventually being considered only as descriptive.

Meyer originally defined "constitutional inferiority", or, as it soon also came to be called, "constitutional psychopathic inferiority" as a remainder group of disturbances which found no place in other, positively defined, psychiatric categories. This contributed to the fact that the psychopathy concept in America never attained the broad collective character which it had in the German-dominated psychiatry. Instead there was a tendency to perceive the diagnosis as a limited syndrome, like the abandoned category moral insanity, which it did largely replace. This was due to the fact that "psychopathy" and its various synonyms were immediately associated with inadequacies in personal qualities such as impulsiveness, egoism, emotional frigidity, aggressiveness, etc., that is, inadequacies which often lead to asocial behavior and criminality.

In recent years the Anglo-Saxon psychopathy concept, as it thus developed, has begun to replace the German in areas where the latter has earlier dominated.

This tendency is even to be seen in German-speaking countries. For a number of years the two different notions of psychopathy have been used simultaneously, e.g. in the Scandinavian countries; this is a state of affairs which caused and still causes a serious conceptual disorder. In the past few years the picture has once again begun to clear, and at least in Sweden the Anglo-Saxon concept of psychopathy has now on the whole been accepted.

It is historically interesting to see that *at the descriptive level* this concept is notably similar to the anomia syndrome described by Rush as early as 1786, that is, derangement in the moral faculty (cf. section 2.4.1). There is also great similarity between the characteristics of the modern Anglo-Saxon notion and those qualities said to distinguish the moral imbecile, moral idiot and born criminal, so drastically depicted during the latter part of the 19th century.

As we have seen, in the period between Rush's anomia and the descriptions of Cleckley and other contemporary researchers on psychopathy (cf. section 6.2.8) we encounter more comprehensive clinical concepts related to the former (Prichard's concept of moral insanity, the German psychopathy concepts). However, there has always existed a tendency to limit these comprehensive concepts to clinical phenomena reminiscent of the Rush syndrome. We find that, soon after Prichard had described it, the moral insanity concept with its broad area of definition was given a more limited, specific content including traits in different combinations, such as egoism, amorality, emotional frigidity, impulsiveness, aggressiveness, spinelessness and an inability to learn from experience in different respects (cf. section 2.6.1).

During the 20th century we can see a similar tendency in regard to the German development. Individual theoreticians such as Schneider fight to maintain intact the originally intended significance of the concept but are finally unable to withstand the forces working in another direction.

What lies behind this tendency? The following interpretation seems reasonable. If one is dealing with a diagnostic concept covering many disparate phenomena such as behavior which breaks the law or is socially highly disapproved of, attention is easily drawn to such qualities. For those individuals less initiated in psychopathology, including laymen in different professions, e.g. lawyers, the concept quite easily becomes limited to solely include attention-seeking forms of behavior.

At the same time another process goes on. The emotionally negative charge inherent in socially unacceptable behavior rubs off, so to speak, on the clinical area in which the behavior is encountered. We are left with a concept that is surrounded by an emotionally negative atmosphere and in relation to this a degrading diagnostic label. These conditions lead to the diagnostician being unwilling to employ the concept in its original meaning, that is, to apply the diagnosis to individuals who by definition belong to the category, but do not exhibit the socially unacceptable symptoms. If the diagnostician does apply the label he then risks being misunderstood and causing his patient unnecessary suffering. Even if he believes in the original denotation he must then conform to the process of shifting meaning affecting the concept in question.

7.3 Viewpoints on Psychodiagnostic Concepts

Classification has always been one of man's basic methods for coming to grips with a seemingly chaotic reality—the so-called concrete world around us as well as the world of thought. This statement also applies to psychiatry, a scientific discipline that has made extreme use of this method (cf. e.g. Menniger et al. 1963). As D. Hack Tuke (cf. section 4.4) stated more than eighty years ago, "the wit of man has rarely been more exercised than in the attempt to classify the morbid phenomena covered by the term insanity" (cited in Kendell 1975, p. vii; cf. chap. 1, note 1).

Hence the ordering of unusual and distinctive behavior into classes—or diagnostics, as it is called in psychiatry—is a prevalent scientific method. However, it also includes dangers. To diagnose can, as has often been the case in the history of psychiatry, become a goal in itself, which detracts the diagnostician from the ultimate aim of his activities, to help the suffering patient.

Additionally one can point to the low level of inter-judge reliability shown by psychiatric diagnoses.[5] These have little value if they do not convey a somewhat definite knowledge content, and if they cannot be used to make certain predictions or determine which therapy is most suitable for the patients in question. Precision in the predictions made is never greater than the certainty and accuracy with which the diagnosis is made. Reliability decreases still further if partly different concepts are used in different countries. The psychopathy demarcations on the European continent and within the Anglo-Saxon world are an example of this. We might also think of the partially different opinions on schizophrenia in Europe and America (cf. Kendell 1975, pp. 70 ff.).

Riese touches on another type of problem related to diagnosis when he writes (1945, p. 466):

> We may indeed ignore or forget their (the classifications') intellectual origin and take the divisions we establish and the species we distinguish for self-sufficient entities, pre-existing as such in nature, independently from our organizing mind. Thus originates what is called an ontologic view of disease and it is this latter which aroused the criticism and scientific revolt of our generation, sometimes inclined to deprive classifications of all their credits.[6]

[5] As a technical term, reliability has several meanings. Usually the word denotes "the complex property of a series of observations, of a measuring instrument, or of the entire measuring process, that makes possible the obtaining of similar results upon repetition; the degree to which such similar results may be predicted; the degree to which measurement is free from random influence" (English & English 1958, p. 456).

[6] Concerning my own opinion on the nature of concepts and their relation to "reality" see chap. 1. This view refers to somatic as well as mental disease concepts. The psychodiagnostic concepts are not distinguished in this respect from the diagnostic concepts within somatic pathology. Psychopathological delimitations are on the other hand different in that they most often are descriptive and thus say little (or implicate contrary opinions) on etiology and prognosis. Hence they make up more arbitrarily delimited categories than do the somatic disease classes which consequently better reflect "reality"; they so to speak "carve nature at the joint" (Zubin 1967, p. 376). Cf. Håkansson (1973).

Another question is whether it is fruitful to speak of mental *disease*, thus suggesting it to be of the same nature as physical disease. Rycroft (1968) disentangles this problem in an easily comprehen-

It is not difficult to find writers in psychiatric literature who give indirect expression to such a view. It may be evident for example in the lack of understanding for categorizations of mental disturbances other than those they themselves advocate. When certain American psychiatrists reject the German concept of psychopathy with the motivation that their adherents have not understood what psychopathy really is, they are as I see it dangerously close to the so-called ontological view.[7] Animated by such conceptions of the psychopathological classes it is not surprising that the debaters often misunderstand each other.

Finally we shall draw attention to yet another danger with psychiatric diagnoses which is especially prominent when seen in the light of historical developments. When we accept a certain diagnostic system, we tend to see people's behavior in such a way that it fits into our schema. Now, if this schema is poorly constructed in a certain respect, if for example it is based on a relatively superficial penetration of symptoms, the above-named tendency has an injurious affect: it prevents us from discovering more fruitful demarcations, hence it hinders scientific progress in the area.

The German notions of psychopathy grew up as we have seen in an environment of certain dominant conceptions within degeneration theory (cf. section 5.1.1). According to this school of thought relationship exists between a great number of psychopathological conditions on the border between health and disease. This viewpoint affected in turn observations of these conditions which led to an emphasis on similarities between them which in our eyes seem insignificant or hardly decisive. On the other hand differences were neglected which now seem essential. Kinberg (cf. section 5.2.5), who started from a partly different frame of reference than did his older German colleagues, conceived the psychopathy category differently: he felt it made up "a hotch-potch of psychiatric, individual psychological, social psychological, characterological and moral distinctive traits --- of quite different origin" (Kinberg 1946, p. 172). On the other hand Vanggaard (cf. section 5.2.5), operating from his psychoanalytical frame of

sible way. To him it is an obvious fact that some psychoses are illnesses of the same kind as physical ailments: "They have demonstrable physical causes which explains the symptoms without reference to either the patient's personality or to any motives which he might have for wishing to be ill" (p. 90). Neuroses on the other hand *resemble* somatic diseases as they produce symptoms which the patients suffer from, but, Rycroft continues (ibid.), "they are inexplicable without reference to patient's personality and motives, i.e. they are creations of the patient himself and not simply the effects of causes operating on him" (p. 90). As regards behavior disorders there are no symptoms in the sense that the "patient" complains of any suffering. In this case it is society, not the "patient", that is opposed to his behavior.

To call neuroses and behavior disorders diseases is, according to Rycroft, "a useful social fiction" (ibid.), since it enables them to be dealt with therapeutically. However, critics e.g. Szasz (1957/58, 1960, 1970) and Mowrer (1960) claim that this fiction—just because it is merely a fiction which most people are unaware of—is dangerous from amongst other things a therapeutic aspect, and ought to be abandoned.

[7] This tendency seems evident in Maughs (1941), Cleckley (1964), and Karpman (1941a, 1947/48), among others.

reference, has great difficulty in understanding how Schneider can gather together phenomena such as psychopathy and neurosis, which differ so widely phenomenologically and from a treatment point of view, and place them under the same diagnostic designation.

More recently discussed examples are the so-called medical and psychological models of mental disorders. The medico-biological view of mental disturbance has a long tradition, stretching back to antiquity. During the 1700s it was revived and once again became current. Rush was one of those who advocated this theory basing his approach on the conviction that mental disorders have physical causes, probably inflammation of the blood vessels of the brain. During the following century various other somatic explanations of mental disease are encountered, including cerebral lesions, organic disease processes in the brain tissue, and various heredity theories.

The medical viewpoint has effected the choice of scientific methods within psychiatry. Its attempt to delimit mental disease categories has essentially been taken from somatic medicine. This was done in the hope that it would be possible to delimit disease units similar to the physical. However, success in this direction has thus far been very limited. Probably it will be shown in the future that the application of the medical model to mental disturbances is, generally speaking, scientifically fruitless, at least in the majority of cases.[8]

There is a special danger with the use of the medical model, that, in his search for the *disease*, the physician may lose sight of the *human being* and his needs. The risk is constant, for it is a much simpler a task to concentrate on the search for diseases, abnormities and defects than it is to understand and correctly treat people in their interaction with a social environment. As long as the physician is capable of shifting between those two stances, that of the diagnostician, seeking the disease, and that of the psychotherapist, no harm is done, but the history of psychiatry shows that far too many fail to perform this *tour de force*.[9]

As we pointed out earlier, Rush was organically-oriented in his veiw of mental derangements. According to Riese, however, this did not prevent him from developing into a good psychotherapist. Riese writes (ibid. p. 110):

> As soon as he (Rush) tried to gain access to the inner world of his patients and to change this world "through the medium of the mind", he seemed to forget the physical causes and the seat of insanity, not unlike Pinel, who forgot classifications when addressing the patient as an individual or to use Rush's term as "a human figure".

[8] The spectacular exception is still the discovery of Treponema pallidum (the bacterium causing syphilis) in the brain tissues of cases of general paralysis. This discovery was made by the Japanese Noguchi in 1911.

[9] The medical approach is sharply attacked in some modern psychotherapeutic literature, e.g. Haugsgjerd (1971). According to these critics the physician tends to fall into the role of engineer or mechanic—the faulty behavior is localized, classified and action taken to "repair" or remove it.

It is interesting to see for how long a period the medico-biological view-point within psychiatry has remained an unquestioned matter of course for physicians, despite its weak empirical foundations. During the latter part of the 19th century, when the psychiatrist was primarily occupied with duties such as hospital administration, classification and somatic care of patients, the view of mental disorders was to a high degree organic (cf. section 3.1). This is to say, then, that there existed a wide gap between the psychiatrist's practical duties and the theoretical superstructure with which he was occupied. Cognitively this gap could hardly have been bridged without a strong identification on the part of the psychiatrist with somatic medicine and its successes. This identification was made possible by the conviction that the territory of his activities, irrational behavior, was only a section of general pathology.[10]

The dominance of the medical model within psychiatry has of course also had consequences for the way psychopathic behavior was regarded. From the beginning of the 19th century it is possible to follow a conflict between lawyers and physicians as to whether certain grossly amoral and criminal acts should or should not be considered manifestations of illness (cf. e.g. section 2.6.2). Many lawyers have been very skeptical of such "medical inventions" (cf. section 4.4) as moral insanity, moral imbecility, etc., since with these terms physicians also implied a partial or complete lack of imputability.[11]

One of the dominant views on psychopathy in our century has been that it is a hereditary defect in the sphere of emotion and conation which is difficult to influence. Yet, due to its etiology, it is best dealt with by a physician, with his medico-biological background. This standpoint has also influenced much research in the area. The best example of this is perhaps the heredity investigations on psychopathy and criminality carried out by German psychiatrists during the 1920s and 1930s.

It is equally important to consider the effects of psychological models upon our perceptions and thinking. Pinel, with his philosophical roots in empiricism, is inclined to place great weight upon the importance of environmental influences for the origin of mental disturbances; in section 2.4.2 we referred to the case of *manie sans délire* which he considered to have resulted, at least in part, from a bad upbring. His views had radical consequences for the mentally ill, when he prescribed a so-called moral treatment in preference to a somatic. This method was later embraced with such confidence in America that it was believed possible to cure almost all cases of insanity with its aid (cf. section 2.6.2).

[10] It is worth noting in this context that the reaction of medical colleagues against Freud at the turn of the century was not primarily caused by a puritanical view of sexuality—Krafft-Ebing for example received praise for his work *Psychopathia sexualis* (cf. section 3.2.4)—but because Freud abandoned what was supposed to be the only scientific approach to "nerve disease", namely the reductionistic, physiological viewpoint, and recommended a psychological theory instead.

[11] The problem is still urgent. In Sweden it is presently being discussed to what extent mentally disturbed law breakers shall be excused from punishment. A government committee (SOU 1977:23) has proposed a tightening up of the presently applicable liberal praxis.

Similarly, psychoanalysis, with its emphasis on environment, conveyed a positive therapeutic spirit where earlier, pessimism had reigned. Initially this brighter view reflected even into the sphere of psychopathy but after a series of failures most psychoanalysts revised their opinions as to the chances of modifying this kind of behavior.

7.4 Observations and Conclusions

In the preceding section we spoke of some of the inadequacies of psychodiagnostic concepts and of the dangers inherent in their use. Certain modern psychotherapeutic schools have taken issue primarily with the "objectification" of the patient which occurs in the diagnostic process, hindering the therapist from meeting the mentally disturbed person as a suffering fellow human being. This point of view is, as we have seen above, not new in the history of psychiatry and psychotherapy. But we should not be so affected by the fear of once again ending up in a "diagnostic culture"[12] where the human being behind the symptoms is forgotten, that we refuse to see the value of diagnostic concepts. Of course each human being is unique when viewed as a whole, but despite this, the symptomatology of each individual contains reactions resembling those of other people. It is these similarities upon which the psychopathologist concentrates when building his concepts. We can hardly afford to deny the scientific progress that can be made when these are taken as a foundation.

"Classifications", writes Riese (1945, p. 466), "owe their existence to an economizing principle of the human intellect. Indeed, if we were to renounce classifications - - - we also condemn ourselves to treat every new experience as the first one - - -".

Even as pure psychotherapists we can never—if we wish to develop our own and other's knowledge of the area—completely avoid the diagnostic concepts. Every psychotherapist has conceptions of his patients, and these conceptions acquire their structure from the theoretic frame of reference within which he operates. Conceptions are also built upon his experience of previous patients—he sees similarities and differences and considers these when deciding how to best treat the new case. Also when attempting to convey knowledge of his patients to colleagues and students the psychotherapist draws on his conceptions of the clients' emotional complexes and behavior. What else are these conceptions than a kind of psychodiagnostic concepts?

In their eagerness to prevent "objectification" of the patient, certain psychotherapists seem to have deceived themselves. They have not—as they believed—actually discarded diagnostic concepts in the real meaning of the term;

[12] The expression was, as far as I can determine, coined by Løchen (1970).

they have only abandoned old in favor of new. It may be that these new concepts are vague and have not been given a label but just the same, they exist as intellectual tools in the work of the therapists.

Thus, as I see it, diagnostic concepts are unavoidable in psychiatry and clinical psychology. But that does not necessarily mean that they must continue to appear as they do today. Instead of avoiding diagnostics, we must attempt to find a balance between the two ways of regarding the human being and his mental disorders, "reconciling both generalization and individualization", as Riese (1951, p. 316) expresses it.

There is a tremendous amount of knowledge compiled in our present diagnostic categories, knowledge we cannot afford to lose. It is only when an obviously better theoretic system has been constructed, a system which takes into account knowledge accumulated during centuries, that we can definitely abandon the latter. As far as I know, no such system exists as yet, so that it would seem scientifically reasonable to continue working with traditional psychopathological concepts and instead attempt to improve them in various ways.

One problem that we have constantly run across in our historical review of psychiatric concepts is the high degree of overlapping between them. This depends partly on the state of things that symptoms are not especially pathognomic, i.e., significant for a specific psychiatric category. Anxiety, for example, can occur in many psychopathological conditions. Impulsive behavior is another example, certainly typical for psychopathy but common even in other disorders. Consequently psychiatric categories are not defined by one or a few specific symptoms, but by a complicated symptom pattern, the growth of which one also usually takes into account. Additionally, in a specific case one or more characteristics may be lacking whereas symptoms typical for other categories exist simultaneously.

The problem is certainly a difficult one, but by no means unique for psychopathology. In zoology, for example, it sometimes proves difficult to decide into which category a certain animal shall be referred. Overlapping of empirical categories is in fact unavoidable, and does not mean that these are worthless. Of course it is necessary to strive towards categories which minimize the number of borderline cases. Hence with regards to delimiting psychopathy it is important that the definition be such that those characteristics it shares with, for example, the neurosis category be as few as possible.

But have not attempts at such delimitation been made earlier? Naturally, but most often it has not been possible to break through the surface of the phenomena, which indeed can be bewildering, so that one has failed to discover those clusters and correlations that seem to occur. The dissection of the psychopathological field has therefore, on the whole been made on an arbitrary basis (cf. note 6, above).

Broadly speaking it was Kraepelin (cf. chap. 3, note 12) who, through his longitudinal studies of a large number of patients, was the first to present empirically established differences of so basic a nature that they could be generally accepted. We refer here to those categories he called dementia praecox and manic-depressive illness.

Arbitrary delimitations are also numerous in the history of the psychopathy notions. It seems, however, that with the present Anglo-Saxon psychopathy concept a syndrome has been encircled which is not so determined by circumstance as has been the case previously. An essential characteristic of this syndrome is the inability to establish deep emotional contact with other human beings. This inadequacy is also coupled to a high degree of impulsiveness. The combination leads to short-sighted egoistic actions, shallow ephemeral contacts, a lack of feelings of shame and guilt, etc.

Evidence that this may be a category comprised of fundamental personality traits is the fact that the syndrome in question has, despite shifting modes of description, pesistently reappeared during the past 200 years. It is perhaps more correct to state that it has never completely disappeared from the literature. The historical support to this syndrom, to which the present dissertation contributes, should in my opinion be granted a degree of value, when one considers the great number of clinicians who through these two centuries have thought that they have seen the above or closely related syndromes.

Another type of support is lent by current research in the area (cf. e.g. Schalling 1977), which presents correlations between the above-named personality traits and variables which have to do with cerebral arousal and mechanisms for regulation of sensory input (cf. section 6.2.9). The extent to which future research can confirm these and similar correlations, will give psychophysiological support for the category of psychopathy, previously defined primarily in descriptive terms.[13]

Thus far we have limited ourselves to speaking of psychopathological classes. This categorical, or, as it is usually phrased, typological[14] outlook has been passed

[13] Such a psychopathy concept comprises, in spite of what has been said, nothing absolute or definitive. New theories, which will in a better fashion than those in existence reflect psychiatry's "object", will probably appear in time. We know very little today as to how those concepts will be defined that will then turn out to be scientifically fruitful.

[14] Usually "typology" means a system for subdivision into classes or types. What then is meant by "type"? This concept is very old (e.g. it is met with in Hippocrates) and it has also various meanings. English & English (1958, p. 567) distinguish nine different senses. Here we will refer to five of them, interesting in our context.

a) "A pattern of qualities that can be distinguished from other patterns and that serves as a model or exemplar in assigning individuals to a class or group; the defining pattern of a category" (ibid.). The psychopathic types set up by Schneider were of this kind (cf. section 5.2.2).

b) "A real or, more often, an ideal or fictitious individual embodying the characteristics of a category in fullest measure. - - - This is a pre-Darwinian concept, but it is influential in much current thinking about type" (ibid.). When certain Anglo-Saxon authors, e.g. McCord & McCord (1964) begin their books and articles on psychopathy with a portrayal of some extremely callous, impulsive, aggressive and asocial individual whom they have met or been told of, they tend, as I see it, to use the type concept in sense (b). There is always a risk with the diagnosis of psychopathy because some less informed people will interpret it according to the meaning intended here. Hence they expect to see a very dangerous and troublesome person which on the whole is wrong.

c) "All the members of a class or category considered as somehow collectively embodying the defining qualities of the group. This meaning is quite common in biology" (ibid.). It seems as if here one does not think of any overlapping worth mentioning between categories. Some psychiatrists

down by medicine, which was itself influenced by the natural history of the 1700s (see chap. 2, note 28). Psychologists especially have attempted to improve psychodiagnostics through the introduction of a dimensional approach. This means that psychopathy is seen as a kind of quality which can vary from a very mildly developed state to one which dominates the personality. Accordingly one does not speak of psychopaths and non-psychopaths but of individuals who are more or less psychopathic. This approach seems to have won many followers, at least in regard to psychopathy and neurosis, even though the official classification system still forces the diagnostician to employ a traditional categorization.

The dimensional approach demands, if it is to be of practical use, that psychopathy variables are measurable.[15] Otherwise they risk the same fate as did Sjöbring's radicals of personality, which in practice nearly always were distorted into traditional clinical-psychological categories (cf. section 5.2.5). Some modern researchers have expressed the hope that in the future they will be able to construct measurement methods with regard to psychopathic behavior which are sufficiently simple and reliable to be employed in practical diagnostics. However, it would appear as if we still have a long way to go before reaching this goal.

The prospects of such a possibility actualizes the question of the advantages and disadvantages of psychodiagnostics, specially in regard to psychopathy. Diagnostic concepts can be improved in different aspects, but this does not in itself lead to a more moral application of them. Therefore, as I see it, an increased awareness of the character of these intellectual tools and the risks encountered with their use, should be an aspect of improved psychodiagnostics. Accordingly, future education in psychopathology should include instruction in the disciplined employment of these concepts and terms.

The psychopathy diagnosis is today heavily loaded with negative associations

have conceived the classes of schizophrenia (dementia praecox) and manic-depressive psychosis according to this concept of type. Thus these two disorders would be mutually exclusive.

d) "An individual having *most* of the defining qualities of the group—an average man, a typical dog" (ibid.). When the term "type" is met with in psychiatric literature it usually has this rather vague meaning. The authors could then equally well have used terms such as "class" or "category". English & English (ibid.) maintain that in this sense the expression *typology* is commonly used. When this word is used in our context it is given this meaning.

e) "The modes of a bipolar distribution where the patterns at the two poles differ but with continuous intergradations; continuous species types: *business* vs. *artist type*" (ibid.). "Psychopath" in this sense is in a line with the dimensional approach.

For a closer examination of the type concept see e.g. Brandell (1941), Ekman (1952), Eysenck & Eysenck (1969).

[15] The concept "dimension" has been widely used in personality psychology though its original meaning referred to such phenomena as physical length and breadth. "Dimension" concerns "any characteristic by which an object or event can be positioned in a quantitative series" (English & English 1958, p. 153). The dimensional approach to mental qualities and personality deviations implies that these are seen as continuously varying along imaginary scales. Simple dimensions can be weighted together to more complex dimensions according to their mutual correlations. If the type concept is conceived in accordance with sense (e) in note 14 above, it will not contrast to the dimen sional approach (cf. Ekman 1952, pp. 120 ff.).

and is still diffuse in meaning. Thus it is currently unsuitable in most practical situations. What then will be the future, if there is success in making the concept more exact and quantifiable (e.g. by operational definition)? In all likelihood the negative aura will remain to a certain extent, since its attributes do after all concern a group of personality traits which often lead to destructive social acts. An emphasis on the *dimension psychopathy* rather than on the *psychopath as a type*, a kind of monster that most practitioners have sought fruitlessly, should, however, lead to a more diversified view.

In such circumstances the psychopathy diagnosis seems to be defendable in certain situations, since it then fulfills a communicative function. It may provide a starting-point for etiological and other research in the area and it may also influence the treatment and therapy of the individuals in question. As many have pointed out (e.g. Nygaard Jansen 1977), psychopathic persons are in fact in need of treatment but a different type to that which has been found suitable in the treatment of neurotics.

Appendix

Terms connected with the psychopathy complex. The table is not complete.

Abnormal character
Abnormal personality
Acting-out personality
Affective insanity
Affective monomania
Anaesthetic symptom complex
Anethopathy
Aomaly of character
Anomia
Anti-social character
Anti-social defect
Autopathy
Born criminal
Born delinquent
Character anomaly
Character mania
Character neurosis
Characteropathy
Congenital brutality
Congenital criminality
Congenital delinquency
Congenital moral degeneration
Congenital moral insanity
Constitutional affective defective
Constitutional defectiveness
Constitutional deficiency
Constitutional immorality
Constitutional inferiority
Constitutional inferiority state
Constitutional perversity
Constitutional psychopath
Constitutional psychic inferiority
Constitutional psychopathic condition
Constitutional psychopathic inferiority
Constitutional psychopathic inferior personality
Constitutional psychopathic personality
Constitutional psychopathic state
Constitutionally psychopathological
Constitutional psychopathy
Criminal psychopathy
Criminal type
Defective delinquent
Defective personality
Degeneracy
Degeneration
Degenerative insanity of the moral type
Degenerative organization
Delirium of actions
"Demifou"
Derangement in the will
Diastrephia
Discordant personality
Egopathy
Emotional deficiency
Emotional insanity
Emotional inferiority
Emotionally unstable
Emotional maladjustment
Ethical degeneration
Ethical dementia
Ethical dullness
Ethical imbecility
Facade personality
Feebly inhibited
Fraudulent personality
Heboidophrenia
Hereditary degenerate
Histrionic personality
Hormepath
Hypophrenia
Idiopathic psychopathy
Idiopathy
Impulse-ridden personality
Impulsive homicidal mania
Impulsive insanity
Impulsive mania
Inadequate personality
Infantoid
Inhibitory insanity
Insanity in the will
Insanity of acts
Insanity of altruistic feelings
Insanity of character
Insanity without delirium
Instinct character

Instinctive criminal
Instinctive insanity
Instinctive madness
Instinctive monomania
Instict-ridden character
Insufficiency of character
Lucid insanity
Lucid mania
Mania without delirium
Mania without delusions
Mental borderline state
Mentally unbalanced
Micronomia
Minor pathergasia
Monomania with consciousness
Moral alienation
Moral anaesthesia
Moral blindness
Moral colorblindness
Moral cretinism
Moral criminal
Moral defectiveness
Moral deficiency
Moral dementia
Moral depravity
Moral derangement
Moral fool
Moral idiocy
Moral imbecility
Moral insanity
Moral insensibility
Moral lunatic
Morally inadequate
Moral mania
Moral monstrosity
Moral moron
Moral obliquity
Moral oligophrenia
Moral paranoia
Moral paresis
Moral perversion
Moral perversity
Moral stupidity
Moral vagabond
Morbid personality
Neurotic character
Neurotic constitution
Original anomaly
Orthopathic personality
Paralysis of volition
Partial diffuse delirium
Pathological personality
Perverse character
Phallic character
Predatory personality
Psychic constitutional inferiority
Psychological ataxia
Psychopathic character
Psychopathic constitution
Psychopathic constitutional inferiority
Psychopathic constitutional state
Psychopathic defective
Psychopatic degeneracy
Psychopathic delinquency
Psychopatic disposition
Psychopatic inferiority
Psychopathic make-up
Psychopathic personality
Psychopathic reaction
Psychopathic state
Psychopathological personality
Psychopathy
Psychosatipath
Reasoning insanity
Reasoning mania
Rudimentary insanity
Semantic dementia
Social defectiveness
Sociopathic personality
Sociopathy
Stoechiomania
Superior unbalanced
Sycophatic personality
Symptomatic psychopathy
Temperamental defect
Temperamental deficiency
Tension-discharge disorder
Transilient personality
Tropopath
Unbalanced
Unstable
Volitional inferiority

References

In addition to the literature referred to in the present thesis, I have included below books and articles which have evidently contributed to my understanding of the problems and ways of thinking discussed.

Periodicals are abbreviated according to *World list of scientific periodicals 1900–1960*. (4th ed.) London: Butterworths, 1963.

SOU = Statens offentliga utredningar.

Aagaard, H. (1974): *Psykopatibegrebet. Kan det spaltes? En teori.* Horsens: Eget forlag.

Abraham, K. (1955): *Clinical papers and essays on psychoanalysis.* London: Hogarth.

Ackerknecht, E.H. (1950): Elisha Bartlett and the philosophy of the Paris clinical school. *Bull. Hist. Med., 24,* 43–60.

– (1953): Broussais or a forgotten medical revolution. *Bull. Hist. Med., 27,* 320–343.

– (1957): *Kurze Geschichte der Psychiatrie.* Stuttgart: Enke.

– (1967): *Medicine at the Paris hospital 1794–1848.* Baltimore: Johns Hopkin's Press.

– (1970): Nonideological elements in the history of psychiatry. In Mora, G. & Brand, J.L. (Eds.), *Psychiatry and its history.* Springfield, Ill.: Thomas. Pp. 223–228.

Ackerknecht, E.H. & Vallois, H.V. (1956): *Franz Joseph Gall, inventor of phrenology, and his collection.* Madison: Univ. Wisconsin Med. School.

Ahlberg, A. (1967): *Filosofins historia. Från den äldsta grekiska antiken till våra dagar* (5. uppl.). Stockholm: Natur och Kultur.

Ahlberg, A., Skard, E. & Winsnes, A.H. (Red.) (1962): *Västerlandets tänkare 3. Från Marx till Sartre.* Stockholm: Natur & Kultur.

Aichhorn, A. (1925): *Verwahrloste Jugend. Die Psychoanalyse in der Fürsorgeerziehung. Zehn Vorträge zur ersten Einführung.* Leipzig.

Albert, R.S., Brigante, T.T. & Chase, M. (1959): The psychopathic personality: a content analysis of the concept. *J. gen. Psychol., 60,* 17–28.

Alexander, F. (1930): The neurotic character. *Int. J. Psychoanal., 11,* 292–311.

Alexander, F. & Healy, W. (1935): *Roots of crime. Psychoanalytic Studies.* New York & London.

Alexander, F. & Ross, H. (1953): *Dynamic psychiatry.* Chicago: Univ. Chicago Press.

Alexander, F. & Shapiro, L.B. (1961): Neuroses, behavior disorders, and perversions. In Alexander F. & Ross, H. (Eds.), *The impact of Freudian psychiatry.* Chicago: Univ. Chicago Press. Pp. 84–106.

Alexander, F.G. & Selesnick, S.T. (1961): *The history of psychiatry: an evaluation of psychiatric thought and practice from prehistoric times to the present.* New York: Allen & Unwin.

Alexander, P. (1963): *Sensationalism and scientific explanation.* London: Routledge & Kegan Paul.

Allm. sv. Läkartidn. (1904–1918), Vols. 1–15.

Altschule, M.D. (1965): *Roots of modern psychiatry. Essays in the history of psychiatry.* (2nd rev. ed.) New York & London: Grune & Stratton.

Am. J. Psychiat. (1950/51), *107,* 628, 868–869.

– (1954/55), *111,* 379–381, 470.

Anderson, E.W. (1962): The official concept of psychopathic personality in England. In Kranz, H. (Hrsg.), *Psychopathologie Heute.* Stuttgart: Thieme. Pp. 243–251.
Anderson, O. (1962): *Studies in the prehistory of psychoanalysis. The etiology of psychoneuroses and some related themes in Sigmund Freud's scientific writings and letters 1886–1896.* (Diss.) Stockholm: Svenska Bokförlaget/Norstedts.
Angel Drake, E.F. (1903): *Hvad en gift kvinna bör veta.* (Övers. fr. eng.). Stockholm.
Antoni, N. (1946): *En bok om nerver.* Stockholm.
Arieff, A.J. & Rotman, D.B. (1948/49): Psychopathic personality: some social and psychiatric aspects. *J. crim. Law Criminol., 39,* 158–166.
Arieti, S. (1963): Psychopathic personality: some views on its psychopathology and psychodynamics. *Compreh. Psychiat., 4,* 301–312.
– (1967): *The intrapsychic self. Feeling, cognition, and creativity in health and mental illness.* New York & London: Basic Books.
Arnold, T. (1784): *Betrachtungen über die Natur, Arten, Ursachen und Verhütung des Wahnsinns oder der Tollheit.* (Übers. aus d. Englischen.) Leipzig.
Aschaffenburg, G. (1906): *Das Verbrechen und seine Bekämpfung.* (2. verb. Aufl.) Heidelberg.
– (1911): *Brottet och dess bekämpande.* (Översättn. fr. arbetets 2. uppl. jämte bearbetning efter svenska förhållanden av O. Kinberg och J. Kinberg.) Stockholm.
Atkin, I. (1958): Psychopathic personalities. *Publ. Hlth, 72,* 168–174.
Baer, A. (1893): *Der Verbrecher in anthropologischer Beziehung.* Leipzig.
Bakan (1966): The influence of phrenology on American psychology. *J. Hist. behav. Sci., 2,* 200–220.
Baney, R. (1970): Perspectives on psychopathy. "*Särskilt vårdkrävande*", d. 1. Psykol. Inst. Stockholms univ. (Stencil.)
Bärmark, J. (1975): Världsbild och vetenskapsideal i humanistisk psykologi. *Häft. kritiska Stud., 6,* 31–48.
Barocas, R. (1970): Some problems in the conception of sociopathy. *Psychiat. Quart., 44,* 674–686.
Bartemeier, L.H. (1931): The neurotic character as a new psychoanalytic concept. *Am. J. Orthopsychiat., 1,* 512–520.
Baruk, H. (1959): *Traité de psychiatrie. Séméiologie – Psychopathologie – Thérapeutique – Étiologie.* Paris: Masson. 2 ts.
– (1967): *La psychiatrie française de Pinel à nos jours.* Paris: Presses Univ. France.
Beard, G.M. (1882): The case of Guiteau – a psychological study. *J. nerv. ment. Dis., 9,* 90–125.
– (1883): *Die Nervenschwäche (Neurasthenia). Ihre Symptome, Natur, Folgezustände und Behandlung.* Leipzig.
– (1896): *Den sexuella neurasthenien. Dess hygien, orsaker, symptom och behandling.* (Övers. fr. eng.) Stockholm.
Bender, L. (1947): Psychopathic behavior disorders in children. In Lindner, R.M. & Seliger, R.V. (Eds.), *Handbook of correctional psychology.* New York. Pp. 360–377.
Bergler, E. (1961): Psychopathic personalities are unconsciously propelled by a defence against a specific type of psychic masochism – "malignant masochism". *Archs crim. Psychodyn., 4,* 416–434.
Berner Öste, M. (1966): *Om termer, begrepp och definitioner.* Rep. fr. Depart. Sociology, Univ. Gothenburg, No. 6.
Beyerholm, O. (1937): *Psykiatriens historie,* København.
Binder, H. (1960): Die psychopathischen Dauernzustände und die abnormen seelischen Reaktionen und Entwicklungen. In Gruhle, H.W., Jung, R., Mayer-Gross, W., & Müller, M. (Eds.), *Psychiatrie der Gegenwart. Forschung und Praxis. Bd. 2: Klinische psychiatrie.* Berlin. Springer. Pp. 180–202.

— (1962): Der psychopathologische Begriff der Neurose. *Schweizer Arch. Neurol. Psychiat., 89,* 185–198.
Binswanger, O. (1905): *Über den moralischen Schwachsinn, mit besonderer Berücksichtigung der Kindlichen Alterstufe.* (In Ziegler, T. & Ziehen, T. [Hrsg.], Sammlung von Abhandlungen aus dem Gebiete der pädagogischen Psychologie und Physiologie. Bd. 8, H. 5.). Berlin.
— (1911): *Über psychopathische Konstitution und Erziehung. Rede gehalten bei der Feier der akademischen Preisverteilung am 17. Juni 1911.* Jena.
Birnbaum, C. (1909): *Über Psychopathische Persönlichkeiten. Eine psychopathologische Studie.* (In Grenzfragen des Nerven- und Seelenlebens. Bd. 10., 1909/10.) Wiesbaden.
— (1914): *Die psychopathischen Verbrecher. Die Grenzzustände zwischen geistiger Gesundheit und Krankheit in ihren Beziehungen zu Verbrechen und Strafwesen.* Berlin.
Bleuler, E. (1896): *Der geborene Verbrecher. Eine kritische Studie.* München.
— (1911): Dementia praecox oder Gruppe der Schizoprhenien. In Aschaffenburg, G. (Hrsg.), *Handbuch der Psychiatrie.* Spez. Teil, 4:1. Wien.
— (1918): *Lehrbuch der Psychiatrie.* (2. erw. Aufl.) Berlin.
— (1962): *Das autistisch-undisziplinierte Denken in der Medizin und seine Überwindung.* (5. Aufl.) Berlin. Springer.
Bleuler, M. (1955): Eugen Bleuler. Die Begründung der Schizophrenielehre. In Schwerte, H. & Sprengler, W. (Hrsg.), *Forscher und Wissenschaftler im heutigen Europa. Bd. 2: Erforscher des Lebens.* Hamburg. Stalling. Pp. 110–117.
— (1962): Vorwort zur Neuausgabe von 1962. In Bleuler, E. *Das autistisch-undisziplinierte Denken in der Medizin und seine Überwindung.* (5. Aufl.) Berlin. Springer. Pp. III–VI.
Bockoven, J.S. (1963): *Moral treatment in American psychiatry.* New York: Springer.
Boismont, B. de (1853): De l'état des facultés dans les délires partiels ou monomanies. *Annls méd.-psychol., 5,* 567–591.
Bonfigli, C. (1879/80): Ulteriori considerationi sull' argogomento della cosi detta pazzia morale (Ulterior considerations on the discussion of the so-called moral insanity). *Am. J. Insan., 36,* 225–229, 476–496.
Borel, J. (1947): *Les déséquilibre psychique. Ses psychoses – sa morale.* Paris: Presses Univ. France.
Boring, E.G. (1957): *A history of experimental psychology.* (2nd ed.) New York: Appleton, Century, Crofts.
— (1963): Science and the meaning of its history. In Boring, E.G., *History, psychology, and science: selected papers.* New York & London: Wiley. Pp. 87–91.
— (1966): A note on the origin of the word psychology. *J. Hist. behav. Sci., 2,* 167.
Börjeson, B., Fredin, E. & Holm, S. (1972):*Sjukdomsmyter. Psykiska störningar och avvikande beteende.* Stockholm: Almqvist & Wiksell.
Bowlby, J. (1954): *Modern och barnets själsliga hälsa* (Fr. English orig. "Maternal care and mental health". WHO Monograph series No. 2. Geneva 1951.) Stockholm: Natur & Kultur.
Bowlus, D.E. & Shotwell, A.M. (1947/48): A Rorschach study of psychopathic delinquency. *Am. J. ment. Def., 52,* 23–30.
Bowman, K.M. & Engle, B. (1957/58): Certain aspects of sex psychopath laws. *Am. J. Psychiat., 114,* 690–697.
Bowman, P.W. (1957/58): The defective delinquent. *Am. J. Psychiat., 114,* 147–151.
Braceland, F.J. (1956/57): Kraepelin, his system and his influence. *Am. J. Psychiat., 113,* 871–876.
Brand, J.L. (1970): The social historian and the history of psychiatry. In Mora, G. & Brand, J.L. (Eds.), *Psychiatry and its history. Methodological problems in research.* Springfield, Ill.: Thomas. Pp. 56–81.

Brandell, G.A. (1941): *Karaktärs- och temperamentstyper. En framställning av nyare karakterologiska forskningsrön.* Stockholm.
Bratt, N. (1969): *Karaktärsutveckling hos barn och ungdom. Anpassning och avvikelse.* (2:a uppl.) Stockholm: Bonniers.
Brattemo, C.E. (1961): Samarbete mellan psykiater och psykologer. Några funderingar kring en interpersonell relationsfråga. *Nord. psykiat. Tidskr., 15,* 178–181. Diskussionsref. pp. 181–187.
Bremer, J. (1951): A social psychiatric investigation of a small community in northern Norway. *Acta psychiat. neurol. Scandinav., Suppl. 62.* Copenhagen.
Brigham, A. (1844/45): Definition of insanity. Nature of the disease. *Am. J. Insan., 1,* 97–116.
Bromberg, W. (1952): American psychiatric achievements in criminology (from 1938 to 1950). In *Proceedings of the 2nd International Congress on Criminology. 3: Psychiatrie-Psychologie-Psychanalyse.* Paris: Presses Univ. France. Pp. 23–35.
– (1961): The psychopathic personality concept reevaluated. *Archs crim. Psychodyn., 4,* 435–457.
Brown, J.A.C. (1961): *Freud and the Post-Freudians.* Penguin Books.
Browne, J.H.B. (1870/71): Moral mania. *Am. J. Insan., 27,* 444–463.
Bruner, J.S. & Allport, G.W. (1940): Fifty years of change in American psychology. *Psychol. Bull., 37,* 757–776.
Buckley, P. & Sander, F. (1974/75): The history of psychiatry from the patient's viewpoint. *Am. J. Psychiat., 131,* 1147–1150.
Bühler, C. (1962): *Värderingar i psykoterapin.* Stockholm: Natur & Kultur.
Bunker, H.A. (1930): From Beard to Freud. A brief history of the concept of neurasthenia. *Med. Rev. Rev., 36,* 108–114.
– (1944): American psychiatric literature during the past one hundred years. In Hall, J.K., Zilboorg, G. & Bunker, H.A., (Eds.), *One hundred years of American psychiatry.* New York. Pp. 195–271.
Burnham, J.C. (1967): *Psychoanalysis and American medicine: 1894–1918. Medicine, Science and culture.* New York: Internat. Univ. Press.
– (1974): The struggle between physicians and paramedical personnel in American psychiatry, 1917–41. *J. Hist. Med., 29,* 93–106.
Burt, C. (1926): The definition and diagnosis of moral imbecility (2). *Br. J. med. Psychol., 6,* 10–46.
Butterfield, L.H. (1951): Introduction. In Butterfield, L.H. (Ed.), *Letters of Benjamin Rush.* Vol. 1. Princeton Univ. Press. Pp. lxi–lxxiii.
Caldwell, J.M. (1944): Neurotic components in psychopathic behavior. *J. nerv. ment. Dis., 99,* 134–148.
Cameron, E. (1953): A theory of diagnosis. In Hoch, P.H. & Zubin, J. (Eds.), *Current problems in psychiatric diagnosis.* New York: Grune & Stratton. Pp. 33–45.
Cammack, J.S. (1947): *Moraliska problem vid sinnessjukdom.* Stockholm.
Campagne (1869): *Traité de la manie raisonnante.* Paris.
Cardno, J.A. (1968): The aetiology of insanity: some early American views. *J. Hist. behav. Sci., 4,* 99–108.
Carlson, E.T. (1956/57): Amariah Brigham: (2) psychiatric thought and practice. *Am. J. Psychiat., 113,* 911–916.
Carlson, E.T. & Dain, N. (1962): The meaning of moral insanity. *Bull. Hist. Med., 36,* 130–140.
Carlson, E.T. & Simpson, M.M. (1965): Benjamin Rush's medical use of the moral faculty. *Bull. Hist. Med., 39,* 22–33.
Carlsson, G. (1948): Personlighetspsykologins mål och metoder. In Sjöstedt, C.E. (Red.), *Problem i den moderna psykologien.* Stockholm. Pp. 70–86.

Carlsson, S. & Rosén, J. (1970): *Svensk historia.* d. 2. (3 uppl.) Stockholm: Bonniers.
Carpelan, H. (1964): Några psykoanalytiska synpunkter på psykiatrisk nosologi. *Nord. psykiat. Tidskr., 18,* 605–616.
Carroll, J.B. (1967): *Språk och tanke.* Stockholm: Wahlström & Widstrand.
Cason, H. (1943): The psychopath and the psychopathic. *J. crim. Psychopath., 4,* 522–527.
– (1948): The concept of the psychopath. *Am. J. Orthopsychiat., 18,* 297–308.
Cassiers, L. (1968): *Le psychopathe delinquant.* (Diss.) Bruxelles: Dessart.
Chatel, J.C. & Peele, R. (1969/70): A centennial review of neurasthenia. *Am. J. Psychiat., 126,* 1404–1413.
Chodoff, P. (1974/75): The diagnosis of hysteria: an overview. *Am. J. Psychiat., 131,* 1073–1078.
Chodoff, P. & Lyons, H. (1957/58): Hysteria, the hysterical personality and "hysterical" conversion. *Am. J. Psychiat., 114,* 734–740.
Ciocco, A. (1936): The historical background of the modern study of constitution. *Bull. Inst. Hist. Med., 4,* 23–38.
Cleckley, H. (1947): The psychopath viewed practically. In Lindner, R.M. & Seliger, R.V. (Eds.), *Handbook of correctional psychology.* New York. Pp. 395–412.
– (1959): Psychopathic states. In Silvano, A. (Ed.), *American handbook of psychiatry.* Vol. 1. New York: Basic Books. Pp. 567–588.
– (1964): *The mask of sanity. An attempt to clarify some issues about the so-called psychopathic personality.* (4th ed.). Saint Louis: Mosby.
Clouston, T.S. (1898): *Clinical lectures on mental diseases.* (5th ed.) London.
Cofer, C.N. & Appley, M.H. (1964): *Motivation: Theory and Research.* New York, London: Wiley.
Conrad, K. (1967): Konstitution. In Gruhle, H.W., Jung, R., Mayer-Gross, W. & Müller, M. (Hrsg.), *Psychiatrie der Gegenwart. Forschung und Praxis*, Bd. I:1A. Berlin, Heidelberg & New York: Springer. Pp. 71–151.
Coventry, C.B. (1844/45): Medical jurisprudence of insanity. *Am. J. Insan. 1,* 134–144.
Craft, M. (Ed.) (1966a): *Psychopathic disorders.* London, New York: Pergamon Press.
– (1966b): The meaning of the term "psychopath". In Craft, M. (Ed.), *Psychopathic disorders.* London, New York: Pergamon Press. Pp. 1–22.
– (1966c): The causation of psychopathic disorder. In Craft, M. (Ed.), *Psychopathic disorders.* London, New York: Pergamon Press. Pp. 56–81.
Cullerre, A. (1890): *Die Grenzen Des Irreseins.* Hamburg.
Curran, D. & Mallinson, P. (1944): Psychopathic personality. *J. ment. Sci., 90,* 266–286.
Dain, N. & Carlson, E.T. (1962): Moral insanity in the United States 1835–1866. *Am. J. Psychiat., 118,* 795–801.
Darling, H.F. (1945): Definition of psychopathic personality. *J. nerv. ment. Dis., 101,* 121–126.
Darwin, C. (1871): *The descent of man, and selection in relation to sex.* London. 2 vols.
Davies, J.D. (1955): *Phrenology, fad and science. A 19th-century American crusade.* New Haven: Yale Univ. Press.
Decker, H.S. (1971): The medical reception of psychoanalysis in Germany, 1894–1907: three brief studies. *Bull. Hist. Med., 45,* 461–481.
Dein, E. (1964): Personlighedstyper ved skizofreni og skizofreniforme psykoser. *Nord. psykiat. Tidskr., 18,* 87–105.
Déjérine, J. (1886): *L'hérédité dans les maladies du systéme nerveux.* (Diss.) Paris.
Delbrück, A. (1891): *Die pathologische Lüge und die psychisch abnormen Schwindler.* Stuttgart.
Despine, P. (1868): *Psychologie naturelle.* Paris. 3 vols.
Deutsch, A. (1944): The history of mental hygiene. In Hall, J.K., Zilboorg, G. & Bunker,

H.A. (Eds.). *One hundred years of American psychiatry*. New York: Columbia Univ. Press. Pp. 325–365.
– (1949): *The mentally ill in America. A history of their care and treatment from colonial times*. (2nd ed.) New York.
Dieckhoff, C. (1898): Die Psychosen bei psychopathisch Minderwerthigen. *Allg. Z. Psychiat., 55,* 215–250.
Diethelm, O. (1947): Basic considerations of the concept of psychopathic personality. In Lindner, R.M. & Seliger, R.V. (Eds.), *Handbook of correctional psychology*. New York. Pp. 384–394.
– (1953): The fallacy of the concept: psychosis. In P.H. Hoch & Zubin, J. (Eds.), *Current problems in psychiatric diagnosis*. New York: Grune & Stratton. Pp. 24–32.
– (1959): Adolf Meyer (1866–1950). In Kolle, K. (Hrsg.), *Grosse Nervenärzte*. 2. Bd. Stuttgart: Thieme. Pp. 129–138.
Dollard, J. & Miller, N.E. (1950): *Personality and psychotherapy. An analysis in terms of learning, thinking, and culture*. New York: McGraw-Hill.
Dornblüth, O. (1894): Zur Lehre von den Geistesstöringen der Entarteten. *Allg. Z. Psychiat., 50,* 681–689.
Dow, E.W. (1924): *Principles of a note-system for historical studies*. New York & London.
Dupré, E. (1925): *Pathologie de l'imagination et de l'emotivité*. Paris.
East, N. (1921): A case of moral imbecility. *Lancet, 102,* 1052–1056.
Egsgaard, J. (1963): Psykopatibegrebet i børnepsykiatrisk belysning. *Nord. Med., 69,* 451–455.
Ehrhardt, H. (1957/58): Psychiatry in post-war Germany. *Am. J. Psychiat., 114,* 414–416.
Eitinger, L. & Retterstøl, N. (1971): *Retspsykiatri*. Oslo: Universitetsforlaget.
Ekman, G. (1952): *Differentiell psykologi*. Stockholm: Gebers.
Ellenberger, H.F. (1970a): Methodology in writing the history of dynamic psychiatry. In Mora, G. & Brand, J.L. (Eds.), *Psychiatry and its history. Methodological problems in research*. Springfield, Ill.: Thomas. Pp. 26–40.
– (1970b): *The discovery of the unconscious. The history and evolution of dynamic psychiatry*. New York: Basic Books.
Ellis, H. (1890): *The criminal*. New York.
– (1892): Criminal anthropology. In Tuke, D.H. (Ed.), *A dictionary of psychological medicine*. Vol. 1. London. Pp. 288–292.
– (1910): *The criminal*. (4th ed., rev. and enlarged.) London.
Elwin, G., Heckscher, S. & Nelson, A. (1971): *Den första stenen. Studiehandbok i kriminalpolitik*. Stockholm: Tidens.
English, H.B. & English, A.C. (1958): *A comprehensive dictionary of psychological and psychoanalytical terms*. New York, London & Toronto: Longmans, Green & Co.
Eriksson, K.H. (1948): *Olika tolkningar av psykopatibegreppet. Försök till funktionsanalys jämte förslag till funktionsbestämning på empirisk grundval*. Lic.-avh. Inst. för pedagogik, Uppsala Universitet. Manus.
– (1957): *Vanart och personlighetsavvikelser*. Uppsala: Appelberg.
Esquirol, J.E.D. (1827): *Allgemeine und spezielle Pathologie und Therapie der Seelenstörungen*. Frei bearbeitet von Dr Karl Christian Hille. Leipzig.
– (1838): *Des maladies mentales*. Bruxelles. 2 ts.
Essen-Möller, E. (1964): Personlighet och psykisk sjukdom. *Nord. psykiat. Tidskr., 18,* 119–128.
Evang, K. (1976): Utvidet eller oprinnelig helsebegrep? *Socialmed. Tidskr., 53,* 304–309.
Ewalt, J.R. (1969/70): Editor's notebook. Classification: chaos or consensus? *Am. J. Psychiat., 126,* 1003–1004.

Ey, H. (1961/62): Hughlings Jackson's principles and the organo-dynamic concept of psychiatry. *Am. J. Psychiat., 118,* 673–682.
– (1964): De psykiska sjukdomarnas natur och klassifikation. Utkast till de psykiska sjukdomarnas biologi. *Nord. psykiat. Tidskr., 18,* 238–255.
Ey, H., Bernard, P. & Brisset, C. (1960): *Manuel de psychiatrie.* Paris: Masson.
Eysenck, H.J. (1960): Classification and the problem of diagnosis. In Eysenck, H.J. (Ed.), *Handbook of abnormal psychology. An experimental approach.* London: Pitman. Pp. 1–31.
– (1964): *Crime and personality.* London: Routledge & Kegan Paul.
Eysenck, H.J., Arnold, W.J. & Meili, R. (1972): *Encyclopedia of Psychology.* Fontana/ Collins. 2 vols.
Eysenck, H.J. & Eysenck, S.B.G. (1969): *Structure and measurement of personality.* London: Routledge & Kegan Paul.
Fabisch, W. (1966): Specialist procedures. In Craft, M. (Ed.), *Psychopathic Disorders.* London, New York: Pergamon Press. Pp. 82–104.
Falret, J. (Falret Jr) (1866/67): On moral insanity. *Am. J. Insan., 23,* 407–424, 516–546.
– (1867/68): On moral insanity (cont.). *Am. J. Insan., 24,* 52–63.
Falret, J.P. (Falret Sr) (1854): *Leçons cliniques de médecine mentale. Faites à l'hospice de la Salpêtrière.* Paris.
– (1864): *Des maladies mentales et des asiles d'aliénés. Leçons cliniques et considerations générales.* Paris.
Fenichel, O. (1945a): Neurotic acting out. In Fenichel, O. *Collected papers.* Vol. 2. New York. Pp. 296–304.
– (1945b): *The psychoanalytic theory of neurosis.* New York.
Féré, C. (1884): La famille névropathique. *Archs Neurol., 7,* 1–43, 173–191.
Feuchtersleben, E. v. (1845): *Lehrbuch der ärzlichen Seelenkunde.* Wien.
– (1847): *The principles of medical psychology being the outlines of a course of lectures.* (Transl. fr. German.) London.
Flournoy, H. (1926): The biological point of view of Adolf Meyer in psychology and psychiatry. *Br. J. med. Psychol., 6,* 85–92.
Flugel, J.C. (1959): *A hundred years of psychology 1833–1933: with additional part on developments 1933–1947.* (2nd ed., repr.) London: Duckworth.
Forssman, H. et al. (1969): *Mentalsjukdomarna och lagen.* Stockholm: AWE/Gebers.
Fotheringham, J.B. (1957): Psychopathic personality – a review. *Can. psychiat. Ass. J., 2,* 52–75.
Foucault, M. (1973): *Vansinnets historia under den klassiska epoken.* (Övers. fr. franskan.) Stockholm: Aldus/Bonniers.
Frängsmyr, T. (1965): Den unge Anton Nyström och positivismen. *Lychnos* 1963/64. Uppsala.
Frankl, V. (1959): Definition und Klassifikation der Neurosen. Der dimensionalontologische Gesichtpunkt. In Frankl, V.E., Gebsattel, V.E. v. & Schultz, J.H. (Hrsg.), *Handbuch der Neurosenlehre und Psychotherapie.* München & Berlin: Urban & Schwarzenberg. Pp. 233–241.
Frankl, V.E., Gebsattel, V.E. v. & Schultz, J.H. (Hrsg.) (1959), *Handbuch der Neurosenlehre und Psychotherapie. 1.Bd.: Allgemeine Neurosenlehre und Allgemeine Psychotherapie. 2.Bd.: Spezielle Neurosenlehre.* München & Berlin: Urban & Schwarzenberg.
Fredriksson, G. (1974): Historia som vetenskap i Sverige: empirism och källkriticism. Anteckningar om en metoddiskussion. *Häft. kritiska Stud., 7,* 7–31.
Freese, J., Lidberg, L. & Thorén, J. (1974): *Rättspsykiatri.* Stockholm: Aldus/Bonniers.
Fremming, K.H. (1948): Arvelige faktorers betydning for sindslidelsernes opstaaelse. *Menneske og Miljø, 3,* 63–69.

Freud, S. (1923): *Das Ich und das Es.* Leipzig, Wien & Zürich.
– (1948): Die Disposition zur Zwangsneurose. Ein Beitrag zum Problem der Neurosenwahl. In Freud, S., *Gesammelte Werke, 8. Bd.* (*Werke aus den Jahren 1909–1913*). London. Pp. 442–452.
– (1949): Some character-types met with in psycho-analytic work. In Freud, S. *Collected papers*, Vol. 4. London. Pp. 318–344.
– (1965): *Sexualteori. Tre studier i sexualteoretiska frågor.* Stockholm: Aldus/Bonniers.
– (1968): *Gesammelte Werke. Chronologisch geordnet. 18. Bd. Gesamtregister.* Frankfurt am Main: Fischer.
– (1969): *Vi vantrivas i kulturen.* Stockholm: Aldus/Bonniers.
– (1973): *Orientering i psykoanalys.* Stockholm: Natur och Kultur.
Frey, T.S. (1977): Psykiatri – humanism – naturvetenskap. Återblick på 100 års akademisk psykiatri i Uppsala. *Läkartidn., 74,* 3434–3437.
Friedenreich, A. (1921): *Kortfattet, speciel Psykiatri.* (3. Udg.) København.
Friedlander, K. (1947): *The psycho-analytical approach to juvenile delinquency. Theory: case-studies: treatment.* London.
Friedman, P. (1959): Sexual deviations. In Silvano, A. (Ed.), *American Handbook of psychiatry*, Vol. 1. New York: Basic Books. Pp. 589–613.
Frosch, J. & Wortis, S.B. (1944/1945): A contribution to the nosology of the impulse disorders. *Am. J. Psychiat., 111,* 132–138.
Fåhraeus, R. (1970): *Läkekonstens historia. Från magi till vetenskap.* Stockholm: Wahlström & Widstrand.
Gadelius, B. (1896): *Om tvångstankar och dermed beslägtade fenomen.* (Diss.) Lund.
– (1900): *Vården av sinnessjuka förr och nu.* Lund.
– (1904): Om förhållandet mellan psykiatri och hjärnanatomi. Installationsföreläsning. *Allm. Sv. Läkartidn., 1,* 321–329, 337–344.
– (1906a): Straffrätt och psykiatri. *Allm. sv. Läkartidn., 3,* 97–107, 113–117.
– (1906b): Om brott och straff. *Allm. Sv. Läkartidn., 3,* 385–399.
– (1908a): *Sinnessjuka och sinnessjukvård.* Stockholm: Bonniers. (Verdandis småskrifter nr 154).
– (1908b): *Förbrytaren och samhället.* Stockholm: Bonniers. (Verdandis småskrifter nr 155.)
– (1913): *Sinnessjukdomar och deras behandling förr och nu.* Stockholm.
– (1917a): Sinnessjukdom. *Nord. fam.-Bok,* (2. uppl.), bd 25, sp. 632–640.
– (1917b): Sinnessjukvård. *Nord. fam.-Bok,* (2. uppl.), bd 25, sp. 640–650.
– (1918): Själspatologiens ställning till det personliga. *Allm. sv. Läkartidn., 15,* 585–614, 865–890, 1481–1502, 1513–1530.
– (1921–24): *Det mänskliga själslivet i belysning av sinnessjukläkarens erfarenhet.* Stockholm. 4 bd.
– (1934): *Tro och helbrägdagörelse jämte en kritisk studie av psykoanalysen.* Stockholm.
Galdston, I. (1956): Freud and romantic medicine. *Bull. Hist. Med., 30,* 489–507.
– (1957): On the utility of medical history. In Galdston, I. (Ed.), *On the utility of medical history.* New York: Intern. Univ. Press. Pp. 3–9.
– (1957/58): International psychiatry. *Am. J. Psychiat., 114,* 103–108.
– (1962): A contribution to the discussion on Dain and Carlson's paper "Moral insanity in the United States 1835–1866". *Am. J. Psychiat., 118,* 800–801.
Galdston, I. (Ed.) (1967): *Historic derivations of modern psychiatry.* New York: McGraw Hill.
Galton, F. (1892): *Hereditary Genius. An inquiry into its laws and consequences.* London.

Gardner, G.E. (1948): The pseudo-psychotic nucleus in the behaviour disorders. *Am. J. Orthopsychiat., 18,* pp. 309–313.
Geijer, R. (1905): *Om samvetet. Sommarkursföreläsningar.* Stockholm.
Geison, G.L. (1969): Darwin and heredity: the evolution of his hypothesis of pangenesis. *J. Hist. Med., 24,* 375–411.
Genil-Perrin, G. (1913): *Histoire des origines et de l'évolution de l'idée de dégénérescence en médecine mentale.* Paris.
Georget (1821): *Ueber die Verrücktheit.* (Uebersetzt und mit Beilagen von J.C.A. Heinroth.) Leipzig.
Gerle, B. (Red.) (1944): *Henrik Sjöbring den 9 juli 1944 från vänner, kolleger, lärjungar.* Lund.
– (1947): *Psykopatibegreppets bankrutt.* Lund.
– (1955): *Personlighetsanalys och psykopatkliché.* Stockholm: Bonniers.
Glueck, B. (1918): Study of admissions to Sing Sing. *Ment. Hyg., 2,* 119–139.
Glueck, S.S. (1925): *Mental disorder and the criminal law. A study in medico-sociological jurisprudence.* Boston.
Glueck, S.S. & Glueck, E.T. (1950): *Unraveling juvenile delinquency.* Cambridge, Mass.: Harvard Univ. Press.
Goffman, E. (1972): *Stigma. Den avvikandes roll och identitet.* Stockholm: Rabén & Sjögren.
Gorton, E. (1895/96): A case of moral insanity. *Am. J. Insan., 52,* 199–206.
Gotfredsen, E. (1950): *Medicinens historie.* Kjøbenhavn: Nytt Nordisk Forlag.
Gough, H.G. (1947/48): A sociological theory of psychopathy. *Am. J. Sociol., 53,* 359–366.
Grange, K.M. (1961): Pinel and eighteenth century psychiatry. *Bull. Hist. Med., 35,* 442–453.
Gray, J.P. (1857/58): Moral insanity. *Am. J. Insan., 14,* 311–322.
– (1865/66): Summary of an article published in The Saturday Review, (Unknown author). *Am. J. Insan., 22,* 133–137.
– (1866/67): Review of W. Griesinger's "A treatise on mental diseases, pathology and therapeutics". *Am. J. Insan., 23,* 330–373.
– (1870/71): The dependence of insanity on physical disease. *Am. J. Insan., 27,* 377–408.
– (1872/73): Thoughts on the causation of insanity. *Am. J. Insan. 29,* 264–283.
– (1881/82): The Guiteau trial. *Am. J. Insan., 38,* 301–448.
Gray, K.G. & Hutchison, H.C. (1964): The psychopathic personality. A survey of Canadian psychiatrists' opinions. *Can. psychiat. Ass. J., 9,* 452–461.
Greenacre, P. (1947): Problems of patient-therapist relationship in the treatment of psychopaths. In Lindner, R.M. & Seliger, R.V. (Eds.), *Handbook of correctional psychology.* New York. Pp. 378–383.
Gregory, I. (1961): *Psychiatry: biological and social.* Philadelphia & London: Saunders.
Griesinger, W. (1845): *Die Pathologie und Therapie der psychischen Krankeheiten.* Stuttgart.
– (1965): *Mental pathology and therapeutics.* (A facsimile of the English ed. of 1867).New York: Hafner.
Grohmann, J.C.A. (1818a): Psychologie der Verbrecher aus Geisteskrankheiten oder Desorganisationen. Ein Versuch. *Z. psych. Aerzte* (Hrsg. von F. Nasse), *1,* 174–200.
– (1818b): Ueber krankhafte Affektionen des Willens: ein Beitrag zur Beurtheilung krimineller Handlungen. *Z. psych. Aerzte, 1,* 471–596.
– (1819a): Innere krankhafte Affektionen des Willens, welche die Unfreiheit verbrecherischer Handlungen bestimmen. *Z. psych. Aerzte, 2,* 157–178.

– (1819b): Eintheilung der psychischen Krankheiten. *Z. psych. Aerzte, 2,* 179–205.
– (1820): Physiologische Momente, welche die Unfreiheit des Willens verbrecherischen Handlungen bestimmen. *Z. psych. Aerzte, 3,* 23–48.
Gruhle, H.W. (1918): *Psychiatrie für Ärzte.* Berlin.
– (1953): *Verstehen und Einfühlen, Gesammelte Schriften.* Berlin: Springer.
Gudden, H. (1908): Das Wesen des moralischen Schwachsinns. *Arch. Psychiat. NervKrankh., 44,* 376–389.
Gurvitz, M. (1951/52): Developments in the concept of psychopathic personality (1900–1905). *Brit. J. Delinq., 2,* 88–102.
Guttmacher, M.S. (1953): Diagnosis and etiology of psychopathic personalities as perceived in our time. In Hoch, P.H. & Zubin, J. (Eds.), *Current problems in psychiatric diagnosis.* New York: Grune & Stratton. Pp. 139–156.
Håkanson, K. (1973): *Psykisk sjukdom: illusioner och realiteter.* Prisma/Verdandi.
Hall, C.S. & Lindzey, G. (Eds.) (1957): *Theories of personality.* New York: Wiley.
Halleck, S. (1966): Psychopathy, freedom and criminal behavior. *Bull. Menninger Clin., 30,* 127–140.
Hammond, W.A. (1882): Reasoning mania: its medical and medico-legal relations; with special reference to the case of Charles J. Guiteau. *J. nerv. ment. Dis., 9,* 1–26.
Harding, G. (1975): Psykiatriundervisning i Sverige före 1860. Linné, Eric Gadelius, Carl Ulrik Sondén och andra. *Lychnos* 1973/74. Uppsala. Pp. 193–216.
– (1975): *Tidig svensk psykiatri. De tre första psykiatriprofessorerna i Stockholm 1861–1902 Öhrström, Björnström, Hjertström och bakgrunden för deras verksamhet.* Verbum.
Hare, R.D. (1970): *Psychopathy: theory and research.* New York: Wiley.
Hare, R.D. & Hare, A.S. (1967): Psychopathic behavior: a bibliography. *Excerpta crim., 7,* 365–386.
Haugsgjerd, S. (1971): *Nytt perspektiv på psykiatrin.* Stockholm: Prisma.
Healy, W. (1924): *The individual delinquent. A text-book of diagnosis and prognosis for all concerned in understanding offenders.* (2nd ed.) Boston.
Heinrich, C.B. (1848): Kritische Abhandlung über die von Prichard als moral insanity geschilderte Krankheitsform. *Allg. Z. Psychiat., 5,* 501–539.
Heinroth, J.C.A. (1818): *Lehrbuch der Störungen des Seelenlebens oder der Seelenstörungen und ihrer Behandlung.* Leipzig. 2 Bde.
Heinze, H. (1942): Psychopathische Persönlichkeiten. In Gütt, A. (Hrsg.), *Handbuch der Erbkrankheiten,* 4.Bd. Leipzig. Pp. 154–335.
Helweg, H. (1939): *Den restslige psykiatri i kort omrids.* København.
– (1948): Psykopathibegrebets uundvaerlighed. *Menneske och miljø, 3,* 105–112.
Henderson, D.K. (1939): *Psychopathic states.* New York.
– (1964): *The evolution of psychiatry in Scotland.* Edinburgh & London: Livingstone.
Henderson, D.K. & Gillespie, R.D. (1927): *A text-book of psychiatry for students and practitioners.* London.
– (1936): *A text-book of psychiatry for students and practitioners.* (4th ed.) London.
– (1944): *A text-book of psychiatry for students and practitioners.* (6th ed.) London.
Heppe, H. (1880): *Soldan's Geschichte der Hexenprozesse. Neu bearbeitet von H. Heppe.* Stuttgart. 2 Bde.
Herd, H. (1922): The diagnosis of moral imbecility. *Lancet, 103,* 741–742, 778.
Hermerén, G. (1973): Historiska förklaringar. *Hist. Tidskr., 93,* 213–238.
Herrlin, A. (1903): *Snille och själssjukdom.* Lund.
– (1904): *Tillräknelighet och själssjukdom. Till straffrättens filosofi.* Lund.
Hesnard, A. (1963): *Psychologie de crime.* Paris: Payot.
Hilgard, E.R. (1956): *Theories of learning.* (2nd ed.) New York: Appleton, Century, Crofts.

Hinsie, L.E. & Campbell, R.J. (1970): *Psychiatric dictionary.* (4th ed.) New York, London, Toronto: Oxford Univ. Press.
Hoch, P.H. & Zubin, J. (Eds.) (1953): *Current problems in psychiatric diagnosis.* New York: Grune & Stratton.
Hoff, H. (1956): *Lehrbuch der Psychiatrie. Verhütung, Prognostik und Behandlung der geistigen und seelischen Erkrankungen.* Basel & Stuttgart: Schwabe. 2 Bde.
Hohnbaum (1848): Ueber Erblichkeit der Geisteskrankheiten. *Allg. Z. Psychiat., 5,* 540–568.
Holmberg, G., Ljungberg, L. & Åmark, C. (Red.) (1968): *Modern Svensk psykiatri.* Stockholm: Almqvist & Wiksell.
Holmes, G. (1956): John Hughlings Jackson 1835–1911. In Kolle, K. (Hrsg.) *Grosse Nervenärzte.* 1. Bd. Stuttgart: Thieme. Pp. 135–144.
Holmström, Å. & Koort, P. (1971): *Hypotes och invarians.* Uppsala: Studentlitteratur.
Holte, A. (1976): The role of the symptom in psychopathological states. *Scand. J. Psychol., 17,* 161–170.
Howells, J.G. (Ed.) (1975): *World history of psychiatry.* London: Bailliére Tindall.
Huddleson, J.H. (1926): The part of conduct disorders in the concept of constitutional psychopathic inferiority. *J. nerv. ment. Dis., 64,* 151–156.
Humbert, F. (1947): Les états dits psychopathiques constitutionnels; termes, notions et limites. *Schweizer Arch. Neurol. Psychiat., 59,* 179–195.
Hunt, J. McV. (1944): *Personality and the behavior disorders. A handbook based on experimental and clinical research.* New York. 2 vols.
Hunter, H. (1959/61): Review of Alfred Lief's (Ed.) "The commonsense psychiatry of Adolf Meyer". *Am. J. Psychiat., 107,* 877–878.
Hunter, R. & Macalpine, J. (1963): *Three hundred years of psychiatry 1535–1860.* London: Oxford Univ. Press.
Hygiea. Medicinsk och pharmaceutisk månadskrift. Register: bd 1–10 (1839–1848), bd 11–22 (1849–1860), bd 23–32 (1861–1870), bd 33–42 (1871–1880), bd 43–50 (1881–1888), bd 51–60 (1889–1898). Stockholm.
Ideler, C.L. (1895): Carl Wilhelm Ideler und seine Stellung in der Entwicklung der Psychiatrie. *Allg. Z. Psychiat., 51,* 851–883.
Isemann, K. (1928): Psychopathie und Konstitution. *J. Psychol. Neurol., 37,* 124–130.
Israel, J. (1964): Sociologiska synpunkter på mentala sjukdomar. In Israel, J. (Red.), *Sociala avvikelser och social kontroll.* Stockholm: Almqvist & Wiksell. Pp. 259–286.
Jacobsen, E. (1965): *De psykiska sjukdomarna.* Stockholm: Rabén & Sjögren.
James, W. (1925): *Psykologi.* (Övers. fr. eng.) Uppsala & Stockholm.
Jaspers, K. (1920): *Allgemeine Psychopathologie für Studierende, Ärzte und Psychologen.* (2. neubearb. Aufl.). Berlin.
Jaynes, J. (1969): Edwin Garrigues Boring: 1886–1968. *J. Hist. behav. Sci., 5,* 99–112.
Jetter, D. (1971): Zur Typologie des Irrenhauses in Frankreich und Deutschland (1780–1840). *Geschichte des Hospitals. Bd. 2.* Wiesbaden: Steiner.
Jewell, J.S. (1881): Influence of our present civilization in the production of nervous and mental diseases. *J. Nerv. ment. Dis., 8,* 1–24.
Johannisson, K. (1974): *Magnetisörernas tid. Den animala magnetismen i Sverige.* Uppsala. (Lychnos-Bibliotek nr 25.)
Johanson, E. (1974): Background and development of youth-prison inmates. A long-term, follow-up study of 128 consecutive inmates and of a control group. *Scand. J. Social Med. Suppl. 9.*
Johnson, A.E. (1922/23): The constitutional psychopathic inferior. A problem in diagnosis. *Am. J. Psychiat., 79,* 467–472.

Jones, E. (1953): *The life and work of Sigmund Freud, Vol. 1: The young Freud, 1856–1900.* London.
– (1955): Preface. In Abraham, K., *Clinical papers and essays on psychoanalysis.* London: Hogarth.
Jonsson, G. (1969): *Det sociala arvet.* Stockholm: Tidens förlag.
Kahn, E. (1928): Die psychopathische Persönlichkeiten. In Bumke, O. (Hrsg.), *Handbuch der Geisteskrankheiten.* Bd. 5. Berlin. Pp. 227–487.
– (1931): *Psychopathic personalities.* (Transl. fr. the German.) New Haven.
– (1956/57): Emil Kraepelin. February 15, 1856 – October 7, 1926 – February 15, 1956. *Am. J. Psychiat., 113,* 289–294.
Kaila, E. (1946): *Personlighetens psykologi.* Stockholm.
Kaila, K. (1957/58): Psychiatry and higher education in Finland. *Am. J. Psychiat., 114,* 1023–1027.
Kallwass, W. (1969): *Der Psychopath. Kriminologische und strafrechtliche Probleme.* Berlin, New York: Springer.
Kanner, L. (1944/45): In Memoriam. Gustav Aschaffenburg 1866–1944. *Am. J. Psychiat., 101,* 427–428.
Kant, J. (1869): *Anthropologie in pragmatischer Hinsicht.* (Herausgegen und erläutert von J.H. von Kirchmann.) Berlin.
Karpas, M.J. (1913): Psychic constitutional inferiority. *New York med. J., 47,* 594–598.
– (1916): Constitutional inferiority. *J. Am. med. Ass., 67,* 1831–1834.
Karpman, B. (Chairman) (1924): The psychopathic individual: a symposium. *Ment. Hyg., 8,* 174–201.
– (1941a): On the need of separating psychopathy into two distinct clinical types: the symptomatic and the idiopathic. *J. crim. Psychopath., 3,* 112–137.
– (1941b): Perversions as neuroses (the paraphiliac neuroses). Their relation to psychopathy and criminality. *J. crim. Psychopath., 3,* 180–199.
– (1947/48): The myth of the psychopathic personality. *Am. J. Psychiat., 104,* 523–534.
– (1948a): Conscience in the psychopath: another version. *Am. J. Orthopsychiat., 18,* 455–491.
– (1948b): Emotional background of white slavery: toward the psychogenesis of so-called psychopathic behavior. *J. crim. Law Criminol., 39,* 1–18.
– (1949): Psychopathy as a form of social parasitism – a comparative biological study. *J. clin. Psychopath., 10,* 160–194.
– (Chairman) (1950): The psychopathic delinquent child. Round table, 1949. *Am. J. Orthopsychiat., 20,* 223–265.
– (1952): A survey of contributions of American psychoanalysis to criminology (1937–1949). In *Proceedings of the 2nd international congress on criminology 3: Psychiatrie, psychologie, psychanalyse.* Paris: Presses Univ. France. Pp. 37–77.
– (1961): The structure of neurosis: with special differentials between neurosis, psychosis, homosexuality, alcoholims, psychopathy and criminality. *Archs crim. Psychodyn. 4,* 599–646.
Kastberg Nielsen, S. (1964): Om Karl Jaspers. *Nord. psykiat. Tidskr., 18,* 465–471.
Kavka, J. (1949): Pinel's conception of the psychopathic state. An historical critique. *Bull. Hist. Med., 23,* 461–468.
Kendell, R.E. (1975): *The role of diagnosis in psychiatry.* London: Blackwell Scient. Publ.
Kennedy, A. (1954): Psychopathic personality and social responsibility. *J. ment. Sci., 100,* 873–881.
Keraval, P. (1886): Aliénation mentale. In *La grande encyclopédie.* T. 2. Paris. Pp. 211–215.
Kiev, A. (1964): Psychiatric nosology – American and British trends. *Can. psychiat. Ass. J., 9,* 114–117.

Kinberg, O. (1908): *Brottslighet och sinnessjukdom. En kritisk studie över det rättsliga förfaringssättet i Sverige rörande för brott tilltalade personer av tvivelaktig sinnesbeskaffenhet samt över behandlingen av kriminella sinnessjuka.* (Diss.) Stockholm.
— (1910): *Om de psykopatologiska tillståndens civilrättsliga betydelse.* Separattryck ur Förhandlingar vid 14:e allmänna svenska läkarmötet i Linköping.
— (1917): *Om den s.k. tillräkneligheten.* Stockholm.
— (1924): *Om s.k. lösdrivare och deras behandling. Socialmedicinsk studie.* Stockholm.
— (1930): *Aktuella kriminalitetsproblem i psykologisk belysning.* Stockholm.
—(1935): *Basic problems of criminology.* Copenhagen.
— (1938): *Festskrift tillägnad Olof Kinberg på 65-årsdagen 23.9.1938 av vänner och lärjungar.* Stockholm.
— (1940): *Miljöbegreppet inom genetisk bio-psykologi.* (Särtryck ur Festskrift tillägnad prof. Nils Stjernberg. Stockholm 1940.)
— (1942): Det biopsykologiska konstitutionsproblemet. In Ahlberg, A. et al. (Red.), *Människokunskap och människobehandling. Praktisk psykologi för envar.* Stockholm. Pp. 327—457.
— (1946): On the concept of "psychopathy" and the treatment of so called "psychopaths". *Theoria, 12,* 169—180.
— (1952): *Lagen och de psykiskt sjuka.* Stockholm: Bonniers.
King, L.S. (1964): A note on so-called "Moral Treatment". *J. Hist. Med., 19,* 297—298.
— (Ed.) (1971): *A history of medicine. Selected Readings.* Hammondsworth: Penguin Books.
Kirchhoff, T. (1912): Geschichte der Psychiatrie. In Aschaffenburg, G. (Hrsg.), *Handbuch der Psychiatrie,* Bd. 4. Leipzig & Wien. Pp. 3—48.
Kitching, J. (1857): Lecture on moral insanity. *Br. med. J., 1,* 334—336, 389—391, 453—456.
Kjellberg, G. (1863): *Om sinnessjukdomarnas stadier. Utkast till en psykiatrisk diagnostik.* (Diss.) Uppsala.
Klassifikation av sjukdomar, 1968. Systematisk företeckning (2. uppl.) Stockholm: Socialstyrelsen, 1969.
Klein, E. (1928/29): Psychologic trends in psychiatry since 1900. *Am. J. Psychiat., 85,* 273—288.
Knight, R.P. (1944/45): The relationship of psychoanalysis to psychiatry. *Am. J. Psychiat., 101,* 777—782.
Knutsson, J. (1977): *Stämplingsteorin — en kritisk granskning.* Brottsförebyggande rådet. Rapport 1977:1. Stockholm.
Koch, J.L.A. (1880): *Psychiatrische Winke für Laien.* (2. Aufl.) Stuttgart.
— (1881): Ueber die Grenzgebiete der Zurechnungsfähigkeit. *Der Irrenfreund, 23,* 81 ff.
— (1888): *Kurzgefasster Leitfaden der Psychiatrie mit besonderer Rücksichtnahme auf die Bedürfnisse der Studierenden, der praktischen Ärzte und der Gerichtsärzte.* Ravensburg.
— (1891—93): *Die psychopathischen Minderwertigkeiten. In drei Abteilungen.* Ravensburg.
— (1894): *Die Frage nach dem geborenen Verbrecher.* Ravensburg.
— (1900): *Abnorme Charactere.* (In Grenzfragen des Nerven- und Seelenlebens, Bd. 1, H. 5, 1900/01.) Wiesbaden.
Kolle, K. (1956): Emil Kraepelin (1856—1926). In Kolle, K. (Hrsg.), *Grosse Nervenärzte.* Bd. 1. Stuttgart: Thieme. Pp. 175—186.
— (1957): *Kraepelin und Freud. Beitrag zur neueren Geschichte der Psychiatrie.* Stuttgart: Thieme.

– (1963): Hans W. Gruhle. In Kolle, K. (Hrsg.) *Grosse Nervenärzte*, Bd. 3. Stuttgart: Thieme. Pp. 69–76.
– (1969): Psychopathen für sich und unter sich. *Psychiat. clin., 2,* 257–267.
Kraepelin, E. (1883): *Compendium der Psychiatrie. Zum Gebrauche für Studirende und Aerzte.* Leipzig.
– (1889): *Psychiatrie. Ein kurzes Lehrbuch für Studirende und Aerzte.* (3. veilfach umgearb. Aufl.) Leipzig.
– (1893): *Psychiatrie, Ein kurzes Lehrbuch für Studirende und Aerzte.* (4. vollst. umgearb. Aufl.) Leipzig.
– (1899): *Psychiatrie. Ein Lehrbuch für Studierende und Ärzte.* (6. vollst. umgearb. Aufl.) Leipzig. 2 Bde.
– (1903–04): *Psychiatrie. Ein Lehrbuch für Studierende und Ärzte.* (7. Aufl.) Leipzig. 2 Bde.
– (1909–1915): *Psychiatrie. Ein Lehrbuch für Studierende und Ärzte.* (8. vollst. umgearb. Aufl.) Leipzig. 4 Bde.
– (1918): *Hundert Jahre Psychiatrie. Ein Beitrag zur Geschichte menschlicher Gesittung.* Berlin.
Krafft-Ebing, R. v. (1882): *Grundzüge der Criminalpsychologie auf Grundlage der deutschen und österreichischen Strafgesetzgebung für Juristen.* (2. gänzlich umgearb. Aufl.) Stuttgart.
– (1885): *Om friska och sjuka nerver.* Stockholm.
– (1888): *Lehrbuch der Psychiatrie auf klinischer Grundlage für praktische Ärzte und Studierende.* (3. umgearb. Aufl.) Stuttgart.
– (1890): *Psychopathia sexualis. Mit besonderer Berücksichtigung der conträren Sexualempfindung. Eine klinsich-forensische Studie.* (5. verm. und umgearb. Aufl.) Stuttgart.
– (1892): *Lehrbuch der gerichtlichen Psychopathologie. Mit Berücksichtigung der Gesetzgebung von Österreich, Deutschland und Frankreich.* (3. umgearb. Aufl.) Stuttgart.
Kraft, I. (1961): Edoard Seguin and 19th century moral treatment of idiots. *Bull. Hist. Med., 35,* 393–418.
Kranz, H. (1959): Abgrenzung gegenüber Psychopathie und Psychose. In Frankl, V., Gebsattel, V. v. & Schultz, J.H. (Hrsg.), *Handbuch der Neurosenlehre und Psychotherapie,* 1. Bd. München & Berlin: Urban & Schwarzenberg. Pp. 263–296.
Krapf, E.E. (1957/58): Response to fellowship lecture on Eugen Bleuler. *Am. J. Psychiat., 114,* 299–302.
Kretschmer, E. (1918): *Der sensitive Beziehungswahn.* Berlin.
– (1922): *Körperbau und Character. Untersuchungen zum Konstitutionsproblem und zum Lehre von den Temperamenten* (2. verm. und verb. Aufl.) Berlin.
– (1926): *Kroppsbyggnaden och karaktären. En undersökning av kroppskonstitutionen och läran om temperamenten.* (Översättn. fr. orig:s 5. och 6. uppl.) Stockholm.
– (1936): *Om hysteri.* Stockholm.
– (1952): *Medicinsk Psykologi.* (2 uppl.) Stockholm: Natur och Kultur.
– (1964): *Gestalter och tankar. En Självbiografi.* (Introd. av G. Harding.) Stockholm: Natur & Kultur.
Krin (1893): Besprechung über Kurella's "Naturgeschichte des Verbrechers", Stuttgart 1893. *Allg. Z. Psychiat., 50,* 403–412.
– (1894): Ueber den gegenwärtigen Stand der Criminal-Anthropologie. *Allg. Z. Psychiat., 50,* 705–713.
Kringlen, E. (1975): *Psykiatri.* (2. rev. utg.). Oslo: Universitetforlaget.
Kurella, H. (1893): *Naturgeschichte des Verbrechens. Grundzüge der Criminellen Anthropologie und Criminalpsychologie.* Stuttgart.

Kurtz, S.G. (1954): James Rush, pioneer in American psychology, 1786–1869. *Bull. Hist. Med., 28,* 50–59.
Lain Entralgo, P. (1948): Sensualism and vitalism in Bichat's "Anatomie Générale". *J. Hist. Med., 3,* 47–64.
Lange, F. (1883): *Om Arvelighedens Indflydelse i Sindssygdommene.* (Diss.) Kjøbenhavn.
– (1898): *De „Sindssyge" og „Invaliderne".* København.
Langfeldt, G. (1936): Der Dieb und der Einbrecher. Eine characterologische Studie. In *Skrifter utgitt av Det Norske Videnskapsakademi i Oslo, 1,* 1–109.
– (1938): Psykopati och kriminalitet. Med ett kasuistiskt bidrag til belysning av forskjellen i den psykopatiske og den neurotiske forbrytertype. In *Festskrift tillägnad Olof Kinberg på 65-årsdagen.* Stockholm. Pp. 227–237.
– (1940): *Forelaesninger i psykiatri og rettspsykiatri for jurister.* Oslo.
– (1941): Den somatiske linje i psykiatrien. *Nord. Tidskr., 17,* 48–69.
– (1947): *Rettspsykiatri for jurister och leger.* Oslo.
– (1965a): History and topical content of the psychopathosis concept. *Int. J. Neuropsychiat., 1,* 11–27.
– (1965b): *Laerebok i klinisk psykiatri.* (3. udg.) Oslo: Aschehoug.
– (1976): *Abnorme karakterer (Psykopater).* Oslo: Universitetforlaget.
Lansburgh, W.N. (1964): *Almqvist och Wiksells sättningsregler. Med appendix: manuskriptets redigering.* Stockholm. Almqvist & Wiksell.
Larsen, A. (1975): *Psykopatibegrebet.* København: Munksgaard.
Laycock, T. (1860): *Mind and brain.* Edinburgh & London. 2 vols.
– (1862): Clinical lectures on the physiognomical diagnosis of disease. *Medical Times & Gazette.* Pp. 1–3, 51–54, 101–103, 151–154, 185, 205, 287–289, 341, 449, 499, 551, 635.
Leibbrand, W. & Wettley, A. (1961): *Der Wahnsinn. Geschichte der abendländischen Psychopathologie.* München: Freiburg.
Leigh, D. (1961): *The historical development of British psychiatry. Vol. 1: 18th and 19th century.* London, New York: Pergamon Press.
Lewis, A. (1963): Henry Maudsley. In Kolle, K. (Hrsg.), *Grosse Nervenärzte.* Bd. 3. Stuttgart: Thieme. Pp. 101–108.
Lewis, N.D.C. (1957/58): Historical roots of psychotherapy. *Am. J. Psychiat., 114,* 795–799.
– (1959): American psychiatry from its beginnings to world war II. In Silvano, A. (Ed.), *American handbook of psychiatry,* Vol. 1. New York: Basic Books. Pp. 3–17.
Lidberg, L. (1974): *"Liten sinnesundersökning". Läkarundersökning enligt § 7 lagen om personundersökning i brottmål.* Stockholm: Proprius.
Lindberg, B.J. (1950): Psykoinfantilism. *Acta Psychiat. Neurol., Suppl. 61,* Copenhagen: Munksgaard.
Lindner (1944): *Rebel without a cause. The hypnoanalysis of a criminal psychopath.* New York: Grune & Stratton.
Lindström, J. (1971): *Vad är vetenskapsteori?* Pedagogiska inst. Göteborgs univ. Stencil.
Linné, C. v. (1907): *Linnés föreläsningar i dietetik.* (Ur ett stort antal lärjungeanteckningar samlade och kritiskt ordnade av A.O. Lindfors.) Uppsala.
Littré, É. & Robin, C. (1865): *Dictionnaire de médecine.* (12. éd.) Paris.
– (1878): *Dictionnaire de médecine.* (14. éd.) Paris.
Liungman, C.G. (1971): *Myten om mentalsjukdomarna. Om mentalsjukdomar och psykiatriska metoder.* Askild & Kärnekull.
Løchen, Y. (1970): *Idealer och realiteter i ett psykiatrisk sykehus. En sociologisk fortolkning.* Oslo: Universitetsforlaget.
Lohman, H. (1973): *Psykisk hälsa och mänsklig miljö.* Stockholm. (Socialstyrelsen redovisar nr 30.)

Lombroso, C. (1887): *Der Verbrecher in anthropologischer, ärztlicher und juristischer Beziehung.* Hamburg.
Lowry, R. (1967): Psychoanalysis and the philosophy of physicalism. *J. Hist. behav. Sci., 3,* 156–167.
Lucas, P. (1847–50): *Traité philosophique et physiologique de l'hérédité naturelle dans les états de santé et de maladie du système nerveux.* Paris. 2 ts.
Ludwig, A.M. & Othmer, E. (1977/78): The medical basis of psychiatry. *Am. J. Psychiat., 134,* 1087–1092.
Lund, D. (1914): Om vanartade och brottsliga barns arvs- och miljöförhållanden. *Social Tidskrift, h. 10.*
– (1918): *Über die Ursachen der Jugendasozialität. Kriminalpsychologische und soziale Untersuchungen mit Einschluss von Familienforschungen in Schweden.* (Diss.) Uppsala.
Lundquist, G. (1938): Om s.k. psykopater och deras behandling. Några synpunkter på en aktuell fråga. In *Festskrift tillägnad Olof Kinberg på 65-årsdagen.* Stockholm. Pp. 259–266.
– (1944): Sol- och vårmannens psykologi. In Gerle, B. (Red.), *Festskrift tillägnad Henrik Sjöbring.* Lund. Pp. 167–174.
– (Red.) (1949): *Modern svensk sinnessjukvård. Den psykiatriska vården förr och nu.* Stockholm.
– (1969): *Psykiatri och mentalhygien. Med kort vägledning i socialpsykiatri.* (9 uppl.) Stockholm: Sv. sjuksköterskeförenings förl.
McCaldon, R.J. (1964): Aggression. *Canad. psychiat. Ass. J., 9,* 502–511.
McCord, W. & McCord, J. (1956): *Psychopathy and delinquency.* New York: Grune & Stratton.
– (1964): *The psychopath: an essay on the criminal mind.* London, New York: Van Nostrand.
Magnan, V. (1893): *Leçons cliniques sur les maladies mentales.* Recueillies et publiées par M. Briand & Legrain. (2. éd.) Paris.
Magnan, V. & Legrain (1895): *Les dégénérés (état mental et syndromes épisodiques).* Paris.
Mahrer, A.R. (1970): *New approaches to personality classification.* New York & London: Columbia Univ. Press.
Maier, H.W. (1908): Über moralische Idiotie. *J. Psychol. Neurol., 13,* 57–81.
Major, R.H. (1954): *A history of medicine.* Oxford: Blackwell. 2 vols.
Marc-Wogau, K. (1963): *Filosofisk uppslagsbok.* Stockholm: Liber.
– (1968): *Logik Vetenskapsteori Argumentationsanalys.* Stockholm: Liber.
Marx, O.M. (1968a): J.C.A. Heinroth (1773–1843) on psychiatry and law. *J. Hist. behav. Sci., 4,* 163–179.
– (1968b): American psychiatry without William James. *Bull. Hist. Med., 42,* 52–61.
– (1968c): Review of Wilhelm Griesinger's "Mental pathology and therapeutics". (A facsimile of the English ed. of 1867. New York: Hafner 1965.) *Bull. Hist. Med., 42,* 286–287.
Maudsley, H. (1868): *The physiology and pathology of mind.* (2nd rev. ed.) London.
– (1874): *Responsibility in mental disease.* (2nd ed.) London.
– (1879): *The pathology of mind.* Being the 3rd ed. of the 2nd part of the "Physiology and pathology of mind", recast, enlarged, and rewritten. London.
– (1883): *Body and will being an essay concerning will in its metaphysical, physiological and pathological aspects.* London.
Maughs, S. (1941): A concept of psychopathy and psychopathic personality: its evolution and historical development. *J. crim. Psychopath., 2,* 329–356, 465–499.

— (1949): Psychopathic personality. Review of the literature 1940–47. *J. clin. Psychopath., 10,* 247–275.
— (1955): Psychopathic personality. Review of the literature 1947–54. *Archs crim. Psychodyn., 1,* 291–325.
Mayer-Gross, W., Slater, E. & Roth, M. (1960): *Clinical Psychiatry* (2n ed.). London: Cassel.
Mayo, T. (1854): *Medical testimony and evidence in cases of lunacy.* London.
Meerloo, J.A.M. (1962): The concept of psychopathy. *Am. J. Psychopather., 16,* 645–654.
Menninger, K.A. (1941): Recognizing and renaming "psychopathic personalities". *Bull. Menninger Clin., 5,* 150–156.
Menninger, K.A., Mayman, M. & Pruyser, P. (1963): *The vital balance. The life process in mental health and illness.* New York: Viking.
Merton, R.K. (1949): *Social theory and social structure. Toward the codification of theory and research.* Glencoe, Ill.
Meyer, A. (1895/96): A review of the signs of degeneration and of methods of registration. *Am. J. Insan., 52,* 344–363.
— (1910): A discussion of some fundamental issues in Freud's psychoanalysis. *New York State Hosp. Bull.,* pp. 827–848
— (1928/29): Thirty-five years of psychiatry in the United States and our present outlook. *Am. J. Psychiat. 85,* 1–31.
— (1944/45): Reevaluation of Benjamin Rush. *Am. J. Psychiat., 101,* 433–442.
— (1951a): From the 17th annual report of the State Commission in lunacy, Sept. 30, 1905. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer. Vol. 2: Psychiatry.* Baltimore: Johns Hopkins Press. Pp. 135–146.
— (1951b): An attempt at analysis of the neurotic constitution. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer. Vol. 2: Psychiatry.* Baltimore: Johns Hopkins Press. Pp. 321–330. (Repr. fr. *Am. J. Psychol., 14* [1903], 354–367.)
— (1951c): A review of recent problems in psychiatry. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer, Vol. 2: Psychiatry.*Baltimore: Johns Hopkins Press, Pp. 331–386. (Repr. fr. Church, A. & Peterson, F. [Eds.], *Nervous and mental diseases.* [4th ed.] 1904, 650–688.)
— (1951d): A few trends in modern psychiatry. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer. Vol. 2: Psychiatry.* Baltimore: Johns Hopkins Press. Pp. 386–404. (Repr. fr. *Psychol. Bull., 1* [1904], 217–240.)
— (1951e): The nature and conception of dementia praecox. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer, Vol. 2: Psychiatry.* Baltimore: Johns Hopkins Press. Pp. 459–466. (Repr. fr. *J. abnorm. Psychol., 5,* [1910/11] 274–285.)
— (1951f): Emil Kraepelin, M.D. 1856–1926. In Winters, E.E. (Ed.), *The collected papers of Adolf Meyer. Vol. 3: Medical teaching.* Baltimore: Johns Hopkins Press. Pp. 521–528. (Repr. fr. *Am. J. Psychiat., 73* [1926/27], 749–755.)
Meyer, J.E. (1961): Diagnostische Einteilungen und Diagnosenschemata in der Psychiatrie. In Gruhle, H.W., Jung, R., Mayer-Gross, W. & Müller, M. (Hrsg.), *Psychiatrie der Gegenwart. Forschung und Praxis. Bd. 3. Soziale und angewandte Psychiatrie.* Berlin: Springer. Pp. 130–180.
Meynert, T. (1884): *Psychiatrie, Klinik der Erkrankungen des Vorderhirns. Begründet auf dessen Bau, Leistungen und Ernährung.* Wien.
Michaels, J.J. (1959): Character structure and character disorders. In Silvano, A. (Ed.), *Handbook of American psychiatry.* Vol. 1. New York: Basic Books. Pp. 353–377.
Midgaard, K. (1962): Karl Jaspers (1883–). In Ahlberg, A., Skard, E. & Winsnes, A.H. (Red.), *Västerlandets tänkare. Från antiken till våra dagar. Del 3: Från Marx till Sartre.* Stockholm: Natur & Kultur. Pp. 241–260.

Miller, R.B. (1951): Newer concept of psychopathic personalities. *Dis. nerv. System, 12,* 330–337.
Misiak, H. & Sexton, V.S. (1966): *History of psychology. An overview.* New York & London: Grune & Stratton.
Möbius, P.J. (1900): *Über Entartung.* (In Grenzfragen des Nerven- und Seelenleben, Bd. 1, H. 3. 1900/01.) Wiesbaden.
– (1902): *Über das Pathologische bei Nietzsche.* (In Grenzfragen des Nerven- und Seelenlebens, Bd. 3, H. 17. 1902/03.) Wiesbaden.
Mohr, P. (1947): Die forensische Bedeutung der Psychopathen. *Schweizer. Arch. Neurol. Psychiat., 60,* 244–268.
Moore, M. (1956/57): Review of H. Cleckley's "The mask of sanity". (3rd ed.) 1955. *Am. J. Psychiat., 113,* 92.
Mora, G. (1959a): Vincenzo Chiarugi (1759–1820) and his psychiatric reform in Florence in the late 18th century. *J. Hist. Med., 14,* 424–433.
– (1959b): Recent American psychiatric developments. In Silvano, A. (Ed.), *American handbook of psychiatry.* Vol. 1. New York: Basic Books. Pp. 18–57.
– (1961): Historiographic and cultural trends in psychiatry: a survey. *Bull. Hist. Med., 35,* 26–36.
– (1963): Review of D. Leigh's "The historical development of British psychiatry. Vol. 1". Oxford: Pergamon. *J. Hist. Med., 18.* 98–99.
– (1970): The psychiatrist's approach to the history of psychiatry. In Mora, G. & Brand, J.L. (Eds.), *Psychiatry and its history. Methodological problems in research.* Springfield: Thomas. Pp. 3–25.
Mora, G. & Brand, J.L. (Eds.) (1970): *Psychiatry and its history. Methodological problems in research.* Springfield, Ill.: Thomas.
Moreau (de Tours), J.J. (1859): *La psychologie morbide.* Paris.
Morel, B.A. (1857): *Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine et des causes qui produisent ces variétés maladives.* Paris, Londres, New York.
– (1860): *Traité des maladies mentales.* Paris.
Mowrer, O.H. (1948): Learning theory and neurotic paradox. *Am. J. Orthopsychiat., 18,* 571–610.
– (1960): "Sin," the lesser of two evils. *Am. Psychol., 15,* 301–204.
Müller, C. (1973): *Lexikon der Psychiatrie. Gesammelte Abhandlungen der gebräuchlichsten psychopathologischen Begriffe*: Berlin, New York: Springer.
Müller, E. (1899): Über "Moral insanity". *Arch. Psychiat. NervKrankh., 31,* 325–377.
Müller, F.C. (Hrsg.) (1893): *Handbuch der Neurasthenie.* Leipzig.
Näcke, P. (1894): *Verbrechen und Wahnsinn beim Weibe mit Ausblicken auf die Criminal-Anthropologie überhaupt.* Wien & Leipzig.
– (1896): Besprechung über J.L.A. Koch's "Die Frage nach dem geborenen Verbracher". Ravensburg 1894. *Allg. Z. Psychiat., 52.* 466–470.
– (1902): *Über die sogenannte "Moral Insanity".* (In Grenzfragen des Nerven- und Seelenlebens, Bd. 3, H. 18, 1902/03.) Wiesbaden.
Neuburger, M. (1945): British and German psychiatry in the second half of the eighteenth and the early nineteenth century. *Bull. Hist. Med., 18,* 121–145.
Nordau, M. (1892–93): *Entartung.* (2. Aufl.) Berlin. 2 Bde.
Nygaard-Jensen, O. (1977): *Psykopati – karakterafvigelse.* København: Munksgaard.
Nyman, A. (1943): *Själsbegreppets förvandlingar.* Stockholm: Gebers.
Nyman, G.E. & Smith, G.J.W. (1959): A contribution to the definition of psychopathic personality. Clinical variants and serial test behaviour in a sample of young female delinquents. In *Lunds Universitets Årsskrift*, avd. 2, bd 55, nr 10. Lund: Gleerup.

Nyström, A. (1895): *Om sinnessjukdomar och hospitalsvård jämte antydningar om sinnessjukas rättsliga skydd.* Stockholm.
Oberndorf, C.P. (1912): Constitutional inferiority and its psychoses. *J. Am. med. Ass., 58,* 249–252.
Ochs, G. (1957): *Die Lehre Lombrosos. Darstellung, Genealogie und Kritik der positiven Strafrechtslehre.* (Diss.) Würzburg: Schimmel.
Ødegård, Ø. (1964): Personlighet og psykisk sykdom. *Nord. psyk. Tidskr., 18,* 105–118.
Oettinger, B. (1902): Some observations upon delusions, impulsive insanity, and moral idiocy. *Am. J. med. Sci., 124,* 1051–1075.
O'Kelly, L.J. & Muckler, F.A. (1955): Introduction to psychopathology. (2nd ed.) Englewood Cliffs, N.J.: Prentice-Hall.
Orange, W. (1892): *Criminal responsibility in relation to insanity.* In Tuke, D.H. (Ed.), *A dictionary of psychological medicine.* Vol. 1. London. Pp. 294–320.
Overholser, W. (1949): An historical sketch of psychiatry. *Clin. Psychopath., 10,* 129–146.
– (1962): Editor's instruction. In Ray, J., *A treatise on the medical jurisprudence of insanity.* Cambridge, Mass.: Harvard Univ. Press. Pp. vii–xvi.
Ozarin, L.D. (1954/55): Moral treatment and the mental hospital. *Am. J. Psychiat., 111,* 371–378.
Pagel, W. (1945): The speculative basis of modern pathology. Jahn Virchow and the philosophy of pathology. *Bull. Hist. Med., 18,* 1–43.
Partridge, G.E. (1927/28): A study of 50 cases of psychopathic personality. *Am. J. Psychiat., 84,* 952–953.
– (1928/29a): Psychotic reaction in the psychopath. *Am. J. Psyciat., 85,* 493–518.
– (1928/29b): Psychopathic personality and personality investigation. *Am. J. Psychiat., 85,* 1053–1055.
– (1930/31): Current conceptions of psychopathic personality. *Am. J. Psychiat., 87,* 53–99.
Pasamanick, B. (1954/55): An obscure item in the bibliography of Isaac Ray. *Am. J. Psychiat., 111,* 164–171.
Petrilowitsch, N. (1958): Beiträge zu einer Struktur-Psychopathologie. In *Bibl. Psychiat. Neurol. Suppl. Fasc. 102.* Basel & New York: Karger.
– (1960): Abnorme Persönlichkeiten. In *Bibl. Psychiat. Neurol. Suppl. Fasc. 111.* Basel & New York: Karger.
Petrilowitsch, N. & Baer, R. (1967): *Psychopathie 1945–1966.* (Teil 2.) *Fortschr. Neurol. Psychiat., 35,* 617–649.
Pichot, P. (1977): Psychopathic behavior: a historical overview. In Hare, R.D. & Schalling, D. (Eds.), *Psychopathic behavior: approaches to research.* London: Wiley. (In press.)
Pinel, P. (1800/01): *Traité médico-philosophique sur l'aliénation mentale ou la manie.* Paris.
– (1906): *A treatise on insanity in which are contained the principles of a new more practical nosology of maniacal disorders* (Transl. fr. the French by D.D. Davis.) London.
– (1809): *Traité médico-philosophique sur l'aliénation mentale* (2[e] éd. entièrement refondue et trésaugmentée.) Paris.
Platt, A.M. & Diamond, B.L. (1965): The origins and development of the "wild beast" concept of mental illness and its relation to theories of criminal responsibility. *J. Hist. behav. Sci., 1,* 355–367.
Pontopiddan, K. (1882): Om Slægtskabsforholdet mellem Forbrydelse og Sindssygdom. *Nord. med. Arch., 14,* nr 5, pp. 1–28; nr 8, pp. 1–15.
– (1886): *Neurasthenien. Bidrag til Skildringen af vor Tids Nervositet.* Kjøbenhavn.

Porot, A. (1960): *Manuel alphabetique de psychiatrie clinique et therapeutique.* (2e éd.) Paris: Presses Univ. France.
Preu, P.W. (1944): The concept of psychopathic personality. In Hunt, J. McV. (Ed.), *Personality and the behavior disorders.* Vol. 2. New York. Pp. 922–937.
Prichard, J.C. (1835): *A treatise on insanity and other disorders affecting the mind.* London.
– (1842): *On the different forms of insanity in relation to jurisprudence.* London.
Quay, H.C. (Ed.) (1963): *Research in psychopathology. Selected readings.* New York, London: Van Nostrand.
– (1965/66): Psychopathic personality as pathological stimulation seeking. *Am. J. Psychiat., 122,* 180–183.
Ray, I. (1861/62): An examination of the objections to the doctrine of moral insanity. *Am. J. Insan., 18,* 112–138.
– (1962): *A treatise on the medical jurisprudence of insanity.* (Ed. by W. Overholser.) Cambridge, Mass.: Harvard Univ. Press.
Regnér, E.G. (1947): Vissa psykopatiers uppkomst. En studie om arv och miljö vid vissa beteenderubbningar. In *Menneske og Miljø, 2,* 162–171.
Reich, W. (1949): *Character-Analysis.*(3rd enlarged ed.) New York.
Reil, J.C. (1803): *Rhapsodieen über die Anwendung der psychischen Curmethode auf Geisteszerrüttungen.* Halle.
– (1808): *Beyträge zur Beförderung einer Kurmethode auf psychischen Wege.* Halle. 2 Bde.
Reinhardt, J.M. & Fisher, E.C. (1948/49): The sexual psychopath and the law. *J. crim. Law Crim., 39,* 734–742.
Reiter, P.J. (1946): *Om Psykopather.* København.
Renander, A. (1967): *Medicinsk termonologi.* Stockholm: Nordiska bokhandeln.
Renwall, P. (1965): *Den moderna historieforskningens principer.* Stockholm: Natur och Kultur.
Ribot, T. (1900): *Själsegenskapernas ärftlighet.* (Översättn. fr. originalets 5:e uppl., Paris 1890.) Stockholm.
Riese, W. (1945): History and principles of classification of nervous diseases. *Bull. Hist. Med., 18,* 465–512.
– (1949): An outline of a history of ideas in neurology. *Bull. Hist. Med., 23,* 111–136.
– (1951a): An outline of a history of ideas in psychoptherapy. *Bull. Hist. Med., 25,* 442–456.
– (1951b): Philippe Pinel (1745–1826) His views on human nature and disease. His medical thought. *J. nerv. ment. Dis., 114,* 313–323.
– (1953): *The conception of disease, its history, its versions and its nature.* New York: Philosophical Library.
– (1956): Philosophical presuppositions of present-day medicine. *Bull. Hist. Med., 30,* 163–174.
– (1958): The pre-Freudian origins of psychoanalysis. In Masserman, J.H. (Ed.), *Science and psychoanalysis, Vol. 1: Integrative studies.* New York & London: Grune & Stratton. Pp. 29–72.
Robins, L.N. (1966): *Deviant children grown up. A sociological and psychiatric study of sociopathic personality.* Baltimore: Williams & Wilkins.
Robinson, K. (1966): Law and practice of psychopathic disorder in England and Wales. In Craft, M. (Ed.), *Psychopathic disorders.* London, New York: Pergamon Press. Pp. 23–31.
Rodger, T.F. (1957/58): European and British psychiatry. *Am. J. Psychiat., 114,* 97–102.
Roos, B.A. (1972): Karl Jaspers psykopatologi. En sammanfattande framställning. *Nord. psykiat. Tidskr., 26,* 19–28.

Rosanoff, A.J. & Orr, F.I. (1911): *A study of heredity of insanity in the light of the mendelian theory*. New York. (Eugenics Record Office Bulletin no. 5.) Repr. fr. *Am. J. Insan., 68,* (1911), 221–261.
Rosen, G. (1940): A theory of medical historiography. *Bull. Hist. Med., 8,* 655–665.
– (1941): Disease and social criticism. A contribution to a theory of medical history. *Bull. Hist. Med., 10,* 5–15.
– (1946): The philosophy of ideology and the emergence of modern medicine in France. *Bull. Hist. Med., 20,* 328–339.
– (1948): The place of history in medical education. *Bull. Hist. Med., 22,* 594–629.
– (1951): Romantic medicine: A problem in historical periodization. *Bull. Hist. Med., 25,* 149–158.
– (1956): Hospitals, medical care and social policy in the French revolution. *Bull. Hist. Med., 30,* 124–149.
– (1968): *Madness in society. Chapters in the historical sociology of mental illness*. London: Routledge & Kegan Paul.
Rosenberg, E.C. (1962): The place of George M. Beard in nineteenth-century psychiatry. *Bull. Hist. Med., 36,* 245–259.
Rosengren, B. & Öfwerström, A. (Red.) (1971): *Modern svensk psykoterapi. En antologi från Psykoterapicentrum*. Stockholm: Prisma.
Rosenthal, D. (1970): *Genetic theory and abnormal behavior*. New York: McGraw Hill.
Rotenberg, M. & Diamond, B.L. (1971): The biblical conception of psychopathy: the law of the stubborn and rebellious son. *J. Hist. behav. Sci., 7,* 29–38.
Ruch, F.L. (1963): *Psychology and life* (6th ed.) Chicago: Scott, Foresman and Co.
Ruitenbeek, H.M. (1966): *Freud and America. An interpretive account of the arrival, impact and special evolution of psychoanalysis in the United States – with projections for the future*. New York & London: Macmillan.
Rümke, H.C. (1947): Über die Notwendigkeit einer Revision der Neurosenlehre. *Schweizer Arch. Neurol. Psychiat., 59,* 326–329.
Runes, D.D. (Ed.) (1947): *The selected writings of Benjamin Rush*. New York.
Rush, B. (1825): *Medizinische Untersuchungen und Beobachtungen über die Seelenkrankheiten*. (Nach der zweiten Originalausgabe teusch bearbeitet und mit einigen Anmerkungen begleitet von G. König.) Leipzig.
– (1827): *Medical inquiries and observations upon the diseases of the mind*. (3rd ed.) Philadelphia.
– (1828): *Själens sjukdomar*. (Efter Dr G. Königs tyska översättning av andra originaluppl.) Jönköping.
– (1947): The influence of physical causes upon the moral faculty (1786). In Runes, D.D. (Ed.), *The selected writings of Benjamin Rush*. New York. Pp. 181–211.
Russel, B. (1961): *Västerlandets visdom*. Stockholm: Forum.
Rycroft, C. (1972): *A critical dictionary of psychoanalysis*. Penguin Books.
Rylander, G. (1968): *Samhället och de psykiskt avvikande*. Stockholm: Aldus/Bonniers.
Rylander, G. & Bendz, E. (1947): *Rättspsykiatri i kort framställning jämte huvuddragen av lagstiftningen rörande psykiskt abnorma*. Stockholm. (Kriminologisk handbok utg. av Karl Schlyter.)
Santos, E.H. & Stainbrook, E. (1949): A history of psychiatric nursing in the nineteenth century, Part 1. *J. Hist. Med., 4,* 48–74.
Saussure, R. de (1946): The influence of the concept of monomania on French medico-legal psychiatry (1825–1840). *J. Hist. Med., 1,* 365–397.
– (1956): Philippe Pinel 1745–1826. In Kolle, K. (Hrsg.), *Grosse Nervenärzte*. Bd. 1. Stuttgart: Thieme. Pp. 216–235.
Savino, M.T. & Mills, A.B. (1967): The rise and fall of moral treatment in California psychiatry: 1852–1870. *J. Hist. behav. Sci., 3,* 359–369.

Schäfer, M.L. (1972): *Der Neurosebegriff. Ein Beitrag zu seiner historischen Entwicklung.* München: Goldmann.
Schalling, D. (1970): *Contributions to the validation of some personality concepts.* (Diss.) Stockholm: Psychol. Laboratories. Univ. Stockholm.
– (1977): Psychopathy-related personality variables and psychophysiology of socialization. In Hare, R.D. & Schalling, D. (Eds.), *Psychopathic behavior: approaches to research.* London: Wiley. (In press.)
Schinz, M. (1906): *Die Moralphilosophie von Tetens.* (Diss.) Leipzig.
Schjelderup, H.K. & Winsnes, A.H. (1965): *Europas filosofi.* Stockholm: Wahlström & Widstrand.
Schlyter, K. (Red.) (1955): *Kriminologi.* Stockholm: Wahlström & Widstrand. (Kriminologisk handbok.)
Schneck, J.M. (1960): *A history of psychiatry.* Springfield: Thomas.
– (1961): Jean-Martin Charcot and the history of experimental hypnosis. *J. Hist. Med., 16,* 297–305.
Schneider, K. (1923): Die psychopathischen Persönlichkeiten. In Aschaffenburg, G. (Hrsg.), *Handbuch der Psychiatrie.* Spez. Teil, 7:1, Leipzig & Wien.
– (1927): Die abnormen seelischen Reaktionen. In Aschaffenburg, G. (Hrsg.), *Handbuch der Psychiatrie.* Spez. Teil, 7:2:1. Leipzig & Wien.
– (1946): *Die psychopathischen Persönlichkeiten.* (8. unver. Aufl.) Wien.
– (1950): *Klinische Psychopathologie.* (3. verm. Aufl.) Stuttgart: Thieme.
– (1958): „Der Psychopath" in heutiger Sicht. *Fortschr. Neurol. Psychiat., 26,* 1–6.
Schoenwald, R.L. (1955): Recent studies of the younger Freud. *Bull. Hist. Med., 29,* 261–268.
Schrenk, M. (1973): *Über den Umgang mit Geisteskranken.* Heidelberg & New York: Springer.
Schröder, J. (1759): Genera morborum. (Diss.) In *Disputationes a C. Linnaeo, bd 4.*
Schuldheis, G. (1898): *Om sinnessjuka fångar i Sverige under åren 1865–1894. Rättsmedicinska och kliniska studier.* (Diss.) Uppsala.
Schüle, H. (1878): Handbuch der Geisteskrankheiten. In Ziemssen, H. v. (Hrsg.), *Handbuch der speciellen Pathologie und Therapie.* Bd. 16. Leipzig.
Schulsinger, F. (1972): Psychopathy: heredity and environment. *Int. J. ment. Hlth, 1,* 190–206.
Schultz, D.P. (1969): *A history of modern psychology.* New York & London: Academic Press.
Schultz-Henke, H. (1949/50): Bemerkungen zum Problem der Psychopathie. *Psychol. Rundsch., 1,* 148–155.
Sederer, L. (1976/77): Moral therapy and the problem of morale. *Am. J. psychiat., 134,* 267–272.
Segerstedt, T. (1912): *Det religiösa sanningsproblemet.* Stockholm.
Segerstedt, T.T. (1937): Moral sense-skolan och dess inflytande på svensk filosofi. In *Lunds Universitets Årsskrift.* N.F. avd. 1, bd 33, nr 8. Lund.
Sellin, T. (1955): En historisk återblick. In Schlyter, K. (Red.) *Kriminologi.* Stockholm: Wahlström & Widstrand. Pp. 1–22. (Kriminologisk handbok.)
Shafer, R.J. (Ed.) (1969): *A quide to historical method.* Homewood, Ill.: Dorsey.
Shakow, D. & Rapaport, D. (1964): *The influence of Freud on American psychology.* Cleveland & New York: World Publishing Co.
Shapiro, D. (1965): *Neurotic Styles.* New York: Basic Books.
Shepherd, M. (1957/58): An English view of American psychiatry. *Am. J. Psychiat., 114,* 417–420.
Shields, J. & Slater, E. (1960): Heredity and psychological abnormality. In Eysenck, H.J. (Ed.), *Handbook of abnormal psychology.* London: Pitman. Pp. 298–343.

Shrubsall, F.C. (1926): The definition and diagnosis of moral imbecility (5). *Br. J. med. Psychol., 6,* 70–83.
Shryock, R.H. (1936): *The development of modern medicine. An interpretation of the social and scientific factors involved.* Philadelphia. London.
– (1944): The beginnings: from colonial days to the foundation of the American Psychiatric Association. In Hall, J.K., Zilboorg, G. & Bunker, H.A. (Eds.), *One hundred Years of American Psychiatry.* New York. Pp. 1–28.
– (1944/45): The psychiatry of Benjamin Rush. *Am. J. Psychiat., 101,* 429–432.
Sigerist, H.E. (1944): Psychiatry in Europe at the middle of the nineteenth century. In Hall, J.K., Zilboorg, G. & Bunker, H.A. (Eds.), *One hundred years of American psychiatry.* New York. Pp. 29–43.
– (1947): The world in 1847, *Bull. Hist. Med., 21,* 462–469.
Singer, C. (1941): *A short history of science to the nineteenth century.* Oxford.
Sjöbring, H. (1913): *Den individualpsykologiska frågeställningen inom psykiatrien.* (Diss.) Uppsala.
– (1919): Psykisk konstitution och psykos. *Svenska läkarsällskapets handlingar, 45,* 462–493.
– (1922): Psykologi och biologi. *Uppsala läkareförenings förhandlingar* N.F. 25.
– (1958): *Struktur och utveckling. En personlighetsteori.* Malmö: Gleerup.
Sjöstrand, W. (1943): *Pedagogik och temperamentslära. En pedagogisk-psykologisk historik fram till mitten av 1700-talet.* Göteborg.
Sjövall, B. (1967): *Psychology of tension. An analysis of Pierre Janet's concept of "tension psychologique" together with an historical aspect.* (Diss.) Stockholm: Svenska bokförlaget/Norstedts.
Slater, E. & Roth, M. (1969): *Mayer-Gross, Slater & Roth: Clinical psychiatry.* (3rd ed.) London: Bailliére, Tindall & Cassell.
Smith, J.C. (1939): *Psykiatriske forelaesninger.* København.
Smith, M.H. (1926): The definition of moral imbecility (3), *Br. J. med. Psychol., 6,* 47–54.
Sommer (1895): Die Criminalpsychologie. Vortrag an der Jahresversammlung d. Vereins d. deutschen Irrenärzte zu Dresden. *Allg. Z. Psychiat., 51,* 782–803.
SOU 1922:46. Betänkande med förslag till lag om tvångsuppfostran åt unga förbrytare m.m. Stockholm.
SOU 1942:59. (1943) Strafflagberedningens betänkande angående strafflagens tillräknelighetsbestämmelser, sinnesundersökning m.m. Stockholm.
SOU 1949:37. Klientelet på arbetshemmen. En socialpsykologisk utredning om försumliga försörjare och störande understödstagare. Stockholm.
SOU 1952:46. Betänkande angående psykopatvård m.m. Stockholm.
SOU 1964:40. Mentalsjukvårdslag. Betänkande avgivet av sinnessjuklagstiftningskommittén. Stockholm.
SOU 1977:23. Psykiskt störda lagöverträdare. Betänkande av 1971 års utredning om behandling av psykiskt avvikande. Stockholm.
Sours, J.A. (1961): Freud and the philosophers. *Bull. Hist. Med., 35,* 326–345.
Southwell, E.A. & Merbaum, M. (1964): *Personality: Readings in Theory and Research.* Belmont, Calif.: Wadsworth.
Spencer, H. (1881): *The principles of psychology.* (3rd ed.) London. 2 vols.
Spitzka, E.C. (1895/96): Review of Max Nordau's "Degeneration". *Am. J. Insan., 52,* 106–117.
Stearns, A.W. (1944/45): Isaac Ray, psychiatrist and pioneer in forensic psychiatry. *Am. J. Psychiat., 101,* 573–584.
Steen, R.H. (1913): Moral insanity. *J. ment. Sci., 59,* 478–486.
Stelzner, H. (1911): *Die psychopathischen Konstitutionen und ihre sociologische Bedeutung.* Berlin.

Stengel, E. (1960): Neurosenprobleme vom anglo-amerikanischen Gesichtspunkt. In Gruhle, H.W., Jung, R., Mayer, W. & Müller, M. (Hrsg.), *Psychiatrie der Gegenwart, Forschung und Praxis, Bd. 2: Klinische Psychiatrie.* Berlin: Springer. Pp. 203–213.
Stibe, S. (1974): *Poul Bjerres människouppfattning och hans syn på religionen.* (Mit deutscher Zusammenfassung.) (Diss.) Stockholm: Almqvist & Wiksell.
Stocking, G.W. (1965): Editorial. On the limits of 'presentism' and 'historicism' in the historiography of the behavioral sciences. *J. Hist. behav. Sci., 1,* 211–217.
Strahl, I. (1960): Olof Kinberg. (Nekrolog.) *Sv. Juristtidn. 45,* 380–383.
Strecker, E.A. & Ebaugh, F.G. (1940): *Practical clinical psychiatry.* (5th ed.). Philadelphia.
Strömgren, E. (1958): *Psykiatri.* (6. udg.) København: Munksgaard.
– (1964): *Psykiatri.* (8. udg.) København: Munksgaard.
– (1976): *Psykiatri* (12. udg.) København: Munksgaard.
Stubbe, H. (1965): *Kurze Geschichte der Genetik bis zur Wiederentdeckung der Vererbungsregeln Gregor Mendels.* (2. Aufl.) Jena: Fischer.
Stumpfl, F. (1959): Heredität und Neurose. In Frankl, V., Gebsattel, V. v. & Schultz, J.H. (Hrsg.), *Handbuch der Neurosenlehre und Psychotherapie.* 2. Bd. München & Berlin: Urban & Schwarzwenberg. Pp. 1–43.
Stürup, G.K. (1968): *Treating the untreatable. Chronic criminals at Herstedvester.* Baltimore: Johns Hopkins Press.
Stybe, S.E. (1965): *Idéhistoria. Vår kulturs idéer och tankar i historiskt perspektiv.* Stockholm: Rabén & Sjögren.
Sutter, J.M. & Pascalis, G. (1960): Déséquilibre psychique. In Porot, A. (éd.), *Manuel alphabethique de psychiatrie clinique et thérapeutique.* (2e éd.) Paris: Presses Univ. France. Pp. 169–174.
Svensson, F. (1908): *Frihet, ansvar och bestraffning.* Stockholm. (Skriftser. Brott och straff.)
– (1909): *Den straffrättsliga tillräkneligheten.* Stockholm.
– (1912): *Psychopathische Verbrecher. 2: Vagabund, Dieb, mehrfacher Mörder* (hingerichtet 1900). Leipzig.
Szasz, T.S. (1957/58): The problem of psychiatric nosology. A contribution to a situational analysis of psychiatric operations. *Am. J. Psychiat., 114,* 405–413.
– (1960): The myth of mental illness. *Am. Psychol., 15,* 113–118.
– (1970): *Psykisk sjukdom – en myt. En grundteori om det personliga beteendet.* Stockholm: Aldus/Bonniers.
Talbot, E.S. (1898): *Degeneracy. Its causes, signs and results.* London.
Tarjan, G. (1948/49): Current thinking regarding psychopaths. *Am. J. ment. Def. 53,* 302–311.
Temkin, O. (1945): An essay on the usefulness of medical history for medicine. *Bull. Hist. Med., 19,* 9–47.
– (1946a): The philosophical background of Magendie's physiology. *Bull. Hist. Med., 20,* 10–35.
– (1946b): Materialism in French and German physology of the early nineteenth century. *Bull. Hist. Med., 20,* 322–327.
– (1947): Gall and the phrenological movement. *Bull. Hist. Med., 21,* 275–321.
– (1956): On the interrelationship of the history and the philosophy of medicine. *Bull. Hist. Med., 30,* 241–251.
Thiele, R. (1956): Wilhelm Griesinger (1817–1868). In Kolle, K. (Hrsg.), *Grosse Nervenärzte.* Bd. 1. Stuttgart: Thieme. Pp. 115–127.
Thomas, R.W. (1926): The definition and diagnosis of moral imbecility (5). *Br. J. med. Psychol., 6,* 55–69.

Tiling, T. (1896): Ueber angeborene moralische Degeneration oder Perversität des Characters. *Allg. Z. Psychiat., 56,* 258–275.
Törnqvist, K.E. (1956): Sjöbring, Gerle och psykopatibegreppet. En kritisk granskning. *Tidskr. Kriminalvård, 11,* 53–67.
– (1966): *Svåra återfallsbrottslingar. En rättspsykiatrisk och kriminologisk jämförelseundersökning av två grupper män, dömda till förvaring vid säkerhetsanstalt.* (English summary.) (Diss.) Stockholm: Norstedt.
Torstendahl, R. (1966): *Introduktion till historieforskningen. Historia som vetenskap.* Stockholm: Natur & Kultur.
Tredgold, A.F. (1914): *Mental deficiency (amentia).* (2nd ed., revised and enlarged.) London.
– (1926): The definition and diagnosis of moral imbecility (1). *Br. J. med. Psychol., 6,* 1–9.
Trélat (1861): *La folie lucide étudiée et considérée au point de vue de la famille et de la société.* Paris.
Tuke, D.H. (1882): *History of the insane.* London.
– (1885/86): Moral or emotional insanity. *J. ment. Sci., 31,* 174–190; 284–286 (discussion).
– (1892a): Classificaiton. In Tuke, D.H. (Ed.), *A dictionary of psychological medicine.* 1st vol. London. Pp. 229–233.
– (1892b): Moral insanity. In Tuke, D.H. (Ed.), *A dictionary of psychological medicine.* Vol. 2. London. Pp. 813–816.
Uddenberg, C.E. (1951): Rättspsykiatri och psykiatrisk diagnostik. *Sv. Läkartidn., 48,* 823–832.
Ullman, L.P. & Krasner, L. (1969): *A psychological approach to abnormal behavior.* Englewood Cliffs, N.J.: Prentice-Hall.
Vanggaard, T. (1968a): Acting out. *Nord. psykiat. Tidskr., 22,* 139–146.
– (1968b): Neurose og psykopati. *Nord. psykiat. Tidskr., 22,* 277–295, 433–435.
– (1975): Neuroser. In Hess Thaysen, J., Karsgaard Christensen, L. & Kjerrulf, K. (Red.), *Medicinsk kompendium.* 2. Bd. (11. udg.) København: Nyt Nordisk Forlag. Pp. 1673–1696.
Veith, I. (1956): On hysterical and hypochondriacal afflictions. *Bull. Hist. Med., 30,* 233–240.
– (1957/58): Psychiatric nosology: from Hippocrates to Kraepelin. *Am. J. Psychiat., 114,* 385–391.
– (1965): *Hysteria: the history of a disease.* Chicago & London: Univ. Chicago Press.
Vestberg, E. (1906): *Bidrag till kännedom om sinnessjukdomarnas familiära uppträdande.* (Diss.) Stockholm.
– (1948): Teorin om endogena sjukdomar. En historisk-kritisk undersökning. In *Svenska läkaresällskapets handlingar (Acta Societatis Medicorim Suecanae),* bd 70.
Visher, J.W. (1922): A study in constitutional psychopathic inferiority. *Ment. Hyg., 6,* 729–745.
Vold, G.B. (1958): *Theoretical Criminology.* New York: Oxford Univ. Press.
Walk, A. (1954): Some aspects of the "moral treatment" of the insane up to 1854. *J. ment. Sci., 100,* 807–837.
Walker, E.A. (1957): The development of the concept of cerebral localization in the nineteenth Century. *Bull. Hist. Med., 31,* 99–121.
Walker, N. (1966): Liberty, liability, culpability. In Craft, M. (Ed.), *Psychopathic disorders.* London, New York: Pergamon Press. Pp. 32–55.
Walter, R.D. (1956): What became of the degenerate? A brief history of a concept. *J. Hist. Med., 11,* 422–429.

Watson, R.J. (1960: The history of psychology: a neglected area. *Am. Psychol., 15,* 251–255.
Wettley, A. (1959): Zur Problemgeschichte der „dégénérecence". *Sudhoff's Arch. Geschichte Med., 43,* 193–212.
Whitehorn, J.C. (1957/58): American psychiatry. *Am. J. Psychiat., 114,* 109–113.
Wigert, V. (1941): *Psykiska sjukdomstillstånd.* d. 1. (5 uppl.) Stockholm.
Willke, I. (1972): *Dokumentation för pedagoger och psykologer.* Lund: Studentlitteratur.
Wilmanns, K. (1914): Die Psychopathien. In Lewandowsky, M. (Hrsg.), *Handbuch der Neurologie,* Bd. 5. Berlin. Pp. 513–580.
Wimmer, A. (1909): *Degenererede børn.* København.
– (1929): *Sindssygdommenes Arvegang og raseforberedende Bestraebelser.* Køpenhavn.
– (1936): *Speciel klinisk Psykiatri for Studerende og Laeger.* Køpenhavn.
Winters, E.E. (Ed.) (1951): *The collected papers of Adolf Meyer.* Baltimore: Johns Hopkins Press. 3 vols.
Wittels, F. (1937): The criminal psychopath in the psychoanalytic system. *Psychoanal. Rev., 24,* 276–291.
– (1946): The contribution of Benjamin Rush to psychiatry. *Bull. Hist. Med., 20,* 157–166.
Woods, E.A. & Carlsson, E.T. (1961): The psychiatry of Philippe Pinel. *Bull. Hist. Med. 35,* 14–25.
Woodward, S.B. (1844/45): Homicidal impulse. *Am. J. Insan., 1,* Pp. 323–326.
Wyrsch, J. (1963): Psychopathologie I: Bedeutung und Aufgabe. Ich und Person. Bewusstsein, Antrieb und Gefühl. In Gruhle, H.W., Jung, R., Mayer-Gross, W. & Müller, M. (Hrsg.), *Psychiatrie der Gegenwart. Forschung und Praxis.* Bd. I:2: Grundlagen und Methoden der Klinischen Psychiatrie. Berlin: Springer. Pp. 1–22.
Ziehen, T. (1894): *Psychiatrie für Ärzte und Studierende.* Berlin.
– (1902): Die Geisteskrankheiten des Kindesalters mit besonderer Berücksichtigung des schulplichtigen Alters, T. 1. In Schiller, H. & Ziehen, T. (Hrsg.), *Sammlung von Abhandlungen aus dem Gebiete der pädagogischen Psychologie und Physiologie,* Bd. 5. Berlin.
– (1904): Die Geisteskrankheiten des Kindesalters. . . T. 2. In Schiller, H. & Ziehen, T. (Hrsg.), *Sammlung von Abhandlungen aus dem Gebiete der pädagogischen Psychologie und Physiologie,* Bd. 5. Berlin.
– (1905): Zur Lehre von den psychopathischen Konstitutionen. *Charité-Annalen, 29,* 279–300.
– (1906): Die Geisteskrankheiten des Kindesalters. . . T. 3. In Schiller, H. & Ziehen, T. (Hrsg.), *Sammlung von Abhandlungen aus dem Gebiete der pädagogischen Psychologie und Physiologie,* Bd. 8. Berlin.
– (1912): Zur Lehre von den psychopathischen konstitutionen. *Charité-Annalen, 36,* 130–148.
Zilboorg, G. & Henry, G.W. (1941): *A history of medical psychology.* New York.
– (1944): Legal aspects of psychiatry. In Hall, J.K., Zilboorg, G. & Bunker, H.A. (Eds.), *One hundred years of American psychiatry.* New York. Pp. 507–584.
– (1954/55): The changing concept of man in present-day psychiatry. *Am. J. Psychiat., 111,* 445–448.
– (1957): Psychology and medical history. In Galdston, I. (Ed.), *On the utility of medical history.* New York: Internat. Univ. Press. Pp. 35–40.
– (1957/58): Eugen Bleuler and present-day psychiatry. *Am. J. Psychiat., 114,* 289–298.

Acta Universitatis Upsaliensis

UPPSALA STUDIES IN EDUCATION

Editors: Karl-Georg Ahlström, Urban Dahllöf, Erik Wallin

1. *Inga Elgqvist-Saltzman* 1976: Vägen genom universitetet. En forskningsöversikt och en empirisk analys av några studievägar inom filosofisk fakultet i Umeå 1968–1975.
2. *Sverker Lindblad* 1976: Simulering i undervisning. En kritisk granskning av artificiell praktik i allmänutbildning.
3. *Urban Dahllöf* 1977: Reforming Higher Education and External Studies in Sweden and Australia.
4. *Leif Isberg* 1978: Arbetsuppgifter, krav och utbildning. En studie rörande domarproblematiken inom lagspelet fotboll.
5. *Mats Myrberg* 1978: Towards an Ergonomic Theory of Text Design and Composition.
6. *Henry Werlinder* 1978: Psychopathy: A History of the Concepts. Analysis of the Origin and Development of a Family of Concepts in Psychopathology.

ISBN 91–554–0782–X
ISSN 0347–1314

Distributor: Almqvist & Wiksell International, Stockholm, Sweden